The Modern Hospital

AUGUST 1954

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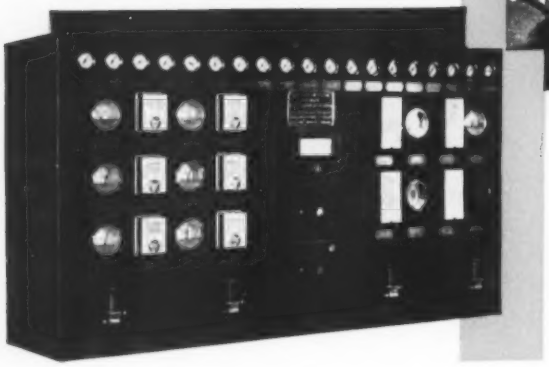

The Moses H. Cone Memorial Hospital, Greensboro, N. C. Samuel Hannaford and Sons, architects, Cincinnati, Ohio; Watson and Hart, mechanical engineers, Greensboro, N. C.; W. H. Singleton Co., Inc., heating and air conditioning contractors, Arlington, Va.

Left, panel-mounted Johnson Control System automatically regulates the temperature and humidity of the primary air supply for room air conditioning units.

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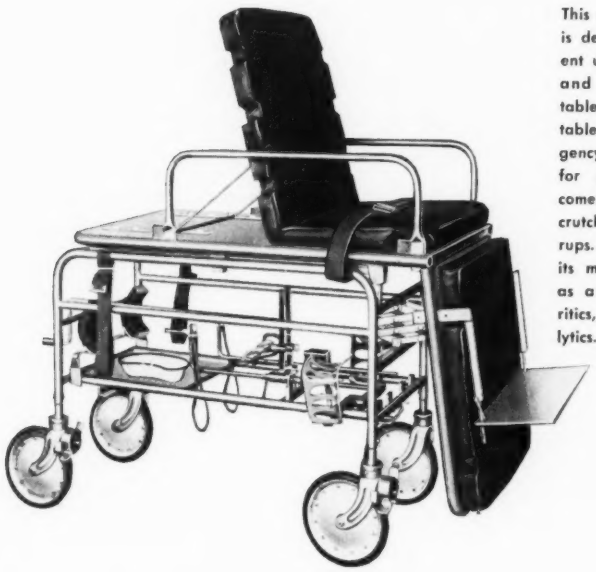

This amazing wheel stretcher is designed for many different uses — as an emergency and auxiliary operating table, as an O-B examining table labor bed for emergency O-B delivery use and for post-operative use. It comes equipped with knee crutches, leg holders and stirrups. Pictured here is one of its most useful applications, as a wheel chair for arthritics, paraplegics and paralytics.

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The Modern Hospital

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AMONG THE AUTHORS


David Babnew Jr.

David Babnew Jr. is administrator of the Northampton-Accomack Memorial Hospital at Nassawadox, Va., a position to which he was appointed this year after serving for three years as director of personnel and public relations at Reading Hospital, Reading, Pa. A graduate of the University of Pennsylvania, Mr. Babnew has a master's degree in industrial management and psychology. He has also done graduate work in business administration and industrial management at Temple University, Philadelphia, and Columbia University, New York City. Before entering the hospital field at Reading, Mr. Babnew did personnel work in the public utilities industry in New Jersey. He also taught economics, finance and industrial management at the Wyomissing Polytechnic Institute, Wyomissing, Pa. His article on the value to hospitals of workers in the older age groups appears on page 55 of this issue.


Alvin Hamburg

Alvin Hamburg, whose article on a new kind of medical record room appears on page 66, has just completed his administrative residency at the Cedars of Lebanon Hospital, Los Angeles. Mr. Hamburg is a graduate of the University of Michigan, with a master's degree in public health which he received in 1950. After two years in the public health field, during which he served on the health education staff of the department of public health at San Diego, Calif., Mr. Hamburg enrolled in the program in hospital administration at Yale University.


Philip J. Lang

Philip J. Lang, whose study of hospital use of prepackaged surgical dressings appears on page 80, is assistant to the director of Touro Infirmary, New Orleans, a position he has held for the last three years. For the last eight years, Mr. Lang has combined hospital administrative assignments and education. He was graduated from the University of Dayton at Dayton, Ohio, in 1949, having worked part time, while taking his college course, in the business office of the Miami Valley Hospital there. He went on to St. Louis University to take the master's degree program in hospital administration, working in the business office of St. Anthony's Hospital, St. Louis. Following graduation from the program in 1951, he took his administrative residency at Touro Infirmary and has been serving as assistant to the director there since that time. **Samuel E. Redfearn,** co-author with Mr. Lang of the article on prepackaged surgical dressings, was formerly associated with Touro Infirmary. Mr. Redfearn is now administrator of the North Hollywood Hospital at North Hollywood, Calif.

Richard C. and **Dwight W. Sleeper,** co-authors of the article on malpractice insurance on page 51, are, respectively, associate consultant and chief consultant of the Insurance Buyers' Council, Harwich Port, Mass. Readers of The Modern Hospital will remember Richard and Dwight Sleeper as authors of the article, "How to Buy Insurance for the Hospital," which was published in 1952 and received The Modern Hospital Gold Medal Award for that year. Turning now to the timely and important subject of insurance for hospital liability for malpractice and negligence resulting in injury and death of patients, the Sleepers have done extensive research in this field, consulting with a number of hospitals, insurance underwriters and loss adjusters.

Roving Reporter

Hoedown at Vassar

It looks as if our hoedown at Vassar Brothers Hospital will be an annual event.

It began when our chief dietitian, at a meeting of department heads, remarked: "The trustees are working so devotedly for our hospital here at Poughkeepsie, giving not only substantial sums toward the deficit fund but endless hours of time to various committees, that I wish we, as employes, could show them our gratitude and appreciation in some *tangible* form."

There was an immediate and warmhearted response to this expression. Ideas flew fast and furious. "Tangible? Just what does that mean—money? Doing something on our own time, using our individual talents, working cooperatively?"

Our New York suburban community is riddled with benefits, but it appeared that another was called for. We were determined to come up with something original, something with an intriguing name and a colorful theme that would capture the imagination of all employes and would draw in the public. Somebody finally said: "Hoedown."

"What's that?"

"Well, when natives in the hills of Kentucky or Tennessee wanted to rest from their work-a-day routine, they, their neighbors and kinsfolk laid down their hoes and gathered together to eat, dance, sing, gossip and, in general, make merry. We can do all that, with the added feature of making money for our hospital."

Never mind that we still remained in the county fair tradition. We had caught hold of a fresh angle and it made a difference.

That was the start. Department heads took back this kernel to their staffs, and the kernel took root and sprouted trunk and branches. Suggestions were so prolific they had to be pruned.

The first decision to be made was when and where. The "when" was the week end before Thanksgiving while corn stalks and pumpkins would still be available "for free" as part of the decorations. It was further decided to hold the hoedown two nights so as to obtain maximum attendance. The "where" was easy—Vassar Hospital's virtually brand new nurses' residence, with its good sized auditorium and large classrooms. The auditorium would be used for a show to be put on by the student nurses; one classroom would be reserved for booths and the other for games; the recreation room would be ideal as a resting room, a smoking room, and a place for square dancing.

Student nurses were excited over the prospect of producing their own show—writing the script, painting the scenery, staging and directing it. Committees were organized, meetings held, and almost before you could insert a hypo needle rehearsals were in progress. Talents of every description emerged: histrionic, dancing, singing, instrument playing, twirling. The director of education of the nursing school advised, stimulated and helped

in whatever capacity she could. After it was over, she claimed it would have been hard to find a more potent morale booster than this hilarious show, some portions of which were professional in quality and all of it tops in entertainment.

Admission to this performance was included in the price of the ticket to the hoedown, namely, 75 cents. The admission fee also entitled the bearer to a door prize. A thousand tickets were printed gratis by a business service that handles a great deal of the hospital's duplicating work. The chief pharmacist and the supervisor of the outpatient department shared the responsibility of their distribution and sale.

Door prizes poured in from every source in response to the irrepressible personalities of the chief dietitian (who was general chairman of the hoedown) and the storeroom manager. The former had only to mention, with her characteristic effervescence, the purpose of the hoedown to the continuous parade of salesmen coming to her office, and gifts began to roll in—turkeys, hams, canned goods, groceries.

The scarecrow nestling cozily in a bale of straw is part of the decoration at the Vassar Hospital hoedown.

The storeroom manager scurried through the town like a hunting dog. He flushed out a radio, a toaster, several brace of partridges, a kitchen wall clock, a fountain pen.

Items not used as door prizes were auctioned off by this versatile dynamo. Besides these, quantities of red, orange, yellow, brown and red crepe paper were donated by a paper company for decorating purposes. This the storeroom manager distributed to the booth chairmen, since each assumed responsibility for designing and decorating his own booth.

One of the first booths to materialize, naturally, was the candy booth. Imaginations were put to work, and the result was an attractive red and white garlanded arrangement, suggesting a box of candy, supported by giant striped peppermint sticks. The six typist-clerks of the record room, inspired by the record librarian, proceeded not only to solicit varieties of fudge, taffy, lollypops, apples on sticks, and popcorn balls, but some, for the first time in their lives, learned how to make candy and turned out delectable batches of sweets under the tutelage of one of the dietitians.

Rubbing elbows with the candy booth was the apron booth. It was only logical that this be in charge of the mistress of the hospital's sewing room. She and her committee worked many hours sewing aprons to wear in the kitchen while preparing meals, aprons to don while cleaning house, aprons for the informal tea party, aprons for the backyard barbecue. In addition, there were the usual pot holders, handkerchiefs, doilies. One

member of the committee dressed a dainty doll in a replica of a V.B.H. nurse's uniform, underneath on out, head down to toe. All this merchandise was displayed in a booth framed with apron shaped board cut-outs, gaily painted in multiple colors. Wash lines, too, were jauntily hung with diversified samples.

Next door was the grocery booth, manned by energetic recruits from the cashier's office. A jangling cow bell advertised that the wheel of fortune would be spun. It was only a step to the "Pantry." Here were shelves loaded with home-made cakes, pies, cookies, breads, pickles and even honey. This was in the capable hands of the laboratory staff.

In one corner was the inevitable fishing pond for youngsters of all ages, manned by members of the assistant administrator's office, the public relations department, and the nursing office, husbands assisting. A child's plastic swimming pool, with real water in it, was used as the pond. Numbered rubber corks were hooked by magnets attached to twig fish poles. Even "dud" hauls were rewarded. The backdrop for this booth, painted by a talented husband, was a life size picture of a whistling Tom Sawyer, with fishing pole over his shoulder and a dog barking at his heels.

The remaining booth in this room featured novelty merchandise—from potted plants to a quilt made by the student nurses and two oil paintings done by an employe. These novelties were displayed in a simulated old-fashioned surrey with fringe on the top.

All booth chairmen were assisted by members of the maintenance crew of the hospital: carpenters, painters and electricians, who cut, sawed, hammered and painted creatively every spare moment.

In the second classroom, patrons had their choice of a variety of games, with attractive prizes for winners. One of the most popular was the baseball dish breaking affair. Cracked and broken plates were supplied by the department of nutrition. Other features were penny pitching, ring tossing, and bowling games. "Barkers" vied with one another in attracting attention to their concessions, convincingly producing a creditable semblance of a county fair midway.

In the adjacent nurses' recreation room, the electrician had rigged up an amplifier attached to a phonograph. It was his job to feed the platters to the machine and to keep the music going. Folk who had tired of the games outside came here to sit and chat, or, if energy still abounded, to release it through square dancing.

The over-all keynote theme, which tied the whole project together, was struck by the decoration committee. The assistant anesthetist and the administrator's secretary, who pursued painting as a hobby, designed and painted huge murals of country scenes with life sized hill billy characters in various acts and poses. Some of these murals were placed in the lobby, transforming the formal living room atmosphere into an approximation of a rural approach to a country fair. The downstairs lobby was treated similarly. The blackboard, stretching the length of the big classroom, was covered by a mural depicting farmhouses, barns, silos, rolling fields, corn shocks and pumpkins; this was painted by a member of the x-ray department. Other members of the decoration committee scoured the countryside for hoes, rakes, milk cans, wagon wheels, wheel barrows, corn shocks, and pumpkins to be placed at appropriate spots. As a final realistic touch, scarecrows were created out of straw, old clothes and hats, and scattered artistically among the shocks and bales of straw.

The general public responded in numbers beyond our expectations, owing to the excellent publicity turned out by the department of public relations. Articles in newspapers, announcements over the radio and in committee meetings at the hospital, posters in store windows, "flyers" in cars, all reached a portion of the public. The first year we cleared $2000; the second year, $2630.

Employes of Vassar Brothers Hospital are fully aware that this hoedown could hardly have been accomplished so successfully without the wholehearted interest, understanding and encouragement of our administrator, Ellison H. Capers, under whose capable leadership department heads work in complete harmony.

We realize, too, that we are indebted to the generosity of certain merchants and business firms in the community who contributed goods.

The idea that began so casually has developed into an annual project and, come fall, we'll be up to our necks once more showing our trustees, our doctors, and our administrator that we're not to be left out or behind.

We suggested, in turning over the proceeds to the trustees, that our gift be used as the beginning of a fund for building a new wing. The trustees were delighted, agreeing that there could hardly be a more powerful impetus to a fund raising campaign than the interest of employes in the growth and expansion of our hospital to meet the health needs of our community.—EMMA P. KNAUSS.

Employes Have Their Day

When Dad or Mom, Sis or Brother talks about his work at Waukesha Memorial Hospital, Waukesha, Wis., the rest of the family now has a mental picture of the work area and, indeed, of the whole hospital. Several times employes had asked Robert M. Jones, the administrator, or their department head for permission to show their families or friends through the hospital.

At a regular meeting of department heads early this year, the group decided to find out how much interest there was on the part of family groups by having an Employes' Day for visiting the institution. It was decided to tie the event in with National Hospital Week. A committee of 11 was appointed, with the purchasing agent as chairman and with at least one representative from each department.

To orient the visitors, the committee decided to start the Employes' Day program with a showing of the film, "House of Mercy." Following the film each employe would then conduct his own family or group of friends on a tour of the hospital, thus enabling him to spend as much time as he and the visitors wished and giving him a chance to emphasize the area in which he worked.

Two weeks in advance of the date invitations were mailed to the home of each employe, and one week in advance notices were posted on all bulletin boards. When the day arrived, 275 visitors showed up, and it was necessary to run the film four times in order to accommodate everyone.

As each employe entered the building he was given a mimeographed map showing a suggested route and then was directed to the training room where the film was shown. Following the movie he started on the tour with his family. Since Employes' Day was on Sunday, the committee members had made arrangements with a representative of each department to be on hand to answer questions. Following the tour refreshments were served in the hospital cafeteria.

Comments from the employes and their families were very favorable. Hospital officials had emphasized the fact that children were invited, and they particularly enjoyed the visit. The only thing that did not work out as satisfactorily as the committee hoped was the fact that only a small percentage of the nonprofessional group came. Perhaps a better job could have been done in contacting this group even though employes from the dietary department, housekeeping department, and laundry were on the committee.

Mr. Jones thinks this project was worth while. During the two or three days in advance of Employes' Day the building began to take on a special glow. There were many cleaning up and reorganizing activities without any suggestions from administration or department heads. The employes seemed to take pride in the building and wanted to show it off in its best condition. The committee expects to repeat the performance next year, but possibly at a different hour so that the day shift can attend.

Tough

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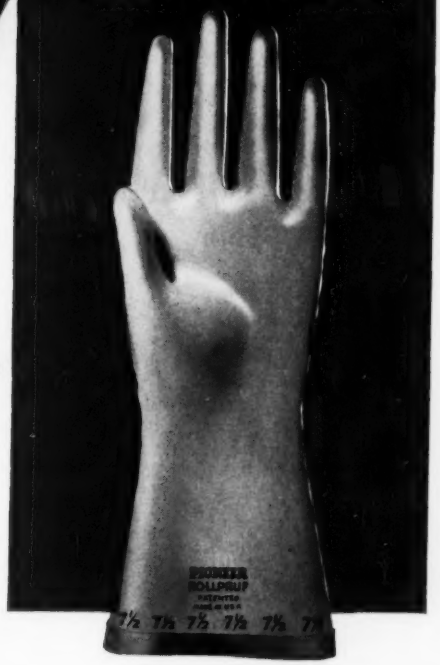

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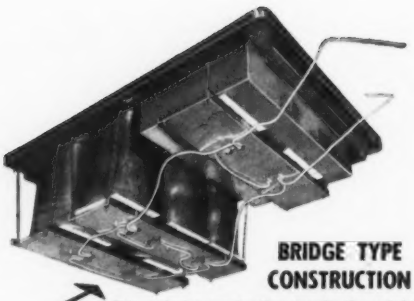

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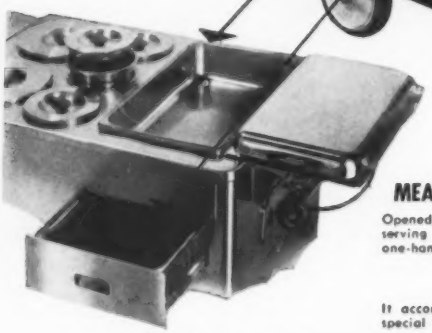

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PAINTS • GLASS • CHEMICALS • BRUSHES • PLASTICS • FIBER GLASS

PITTSBURGH PLATE GLASS COMPANY

IN CANADA: CANADIAN PITTSBURGH INDUSTRIES LIMITED

Dr. Warwick T. Brown, Administrator of Central Dispensary and Emergency Hospital, Washington, D. C., studies chart of departmental dressings costs prepared by *Curity* Representative Floyd Weincek as part of *Curity* Dressings Survey.

How a *Curity* Dressings Survey
HELPS HOSPITAL THREE WAYS

Survey at Washington Hospital Contributes to Cost Control, Patient Care . . . and Saves Money

Here are the results of the *Curity* Dressings Survey conducted at Central Dispensary and Emergency Hospital, Washington, D. C., by *Curity* Representative Floyd Weincek:

1. **IMPROVED COST CONTROL**—Thorough cost analysis revealed both unit and dollar consumption of dressings for each department . . . and provided ratios of consumption to departmental activity—the key to effective cost control.
2. **BETTER PATIENT CARE**—Several opportunities were found to improve dressings practice. (Example: *Kerlix*® Gauze recommended for stump and extremity dressings. Softer, semi-elastic and more absorbent than ordinary gauze . . . makes neat, snug bandage that stays in place.)
3. **LOWER DRESSING COSTS**—Savings totaled $1,765.60 a year, or $8.28 per active bed. (Example: Report showed how the hospital could save $397.86 a year on adhesive alone.)

Wide experience and up-to-date knowledge make *Curity* men like Mr. Weincek experts in the *best* as well as the *most economical* dressings practices. Ask your *Curity* representative about a Dressings Survey that can be so valuable to your hospital.

Curity
REG. U.S. PAT. OFF.

DRESSINGS
SURVEYS

BAUER & BLACK

Division of The Kendall Company
309 West Jackson Blvd.
Chicago 6, Illinois

ANNOUN

the Entirely NEW

TOASTMASTER DE LUXE HOT-FOOD SERVER

Holds cooked foods at the peak of perfection for hours!
Look at all these new features!

HOLDS #200 12"x20" PANS!

New ready-reference instruction tray shows recommended temperature and humidity settings.

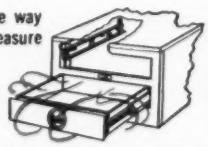
New cool, finger-touch, recessed Bakelite handles.

New "HOT" and "COLD" indicator . . . can be set to show when food is ready to serve.

New precise humidity regulator provides exact moisture control for each drawer.

New recessed thermostat . . . signal light indicates when unit is in use.

Drawers open all the way for easy access; measure 5¼" deep x 22½" long x 13½" wide, to accommodate No. 200 pans.



Drawers, drawer tops and roller channels come out completely for easy cleaning. Self-locking latch.

Unique six-side air circulation around drawers keeps food moist or crisp, as desired.

Now you can safely cook ahead to meet peak demands.

Now cooked foods in standard-size pans can be easily transferred to or from the Toastmaster Hot-Food Server.

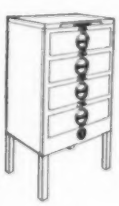
Now you can speed service at all three meals by cooking in advance.

Now you can eliminate food losses caused by shrinkage, drying-out and loss of flavor.

3-Drawer Model
†$375.00

OTHER TOASTMASTER DE LUXE HOT-FOOD SERVERS

2-Drawer Model †$275.00



4-Drawer Model †$435.00

†Prices slightly higher in Pacific Coast states.

See these NEW products on display *NOW*

TOASTMASTER

©"Toastmaster" is a registered trademark of McGraw Electric Company, makers of "Toastmaster" Toasters, "Toastmaster" Waffle Bakers.

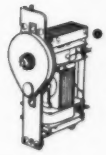
CING

the Sensationally NEW TOASTMASTER POWERMATIC TOASTER

The greatest innovation in automatic toasters in more than 20 years!

Just drop in the bread—toasting starts instantly!

4-Slice Model †$134.50



- **Powerful motors** automatically lower the bread, start it toasting, and serve it up fast—without any attention.
- **Newly engineered** to provide the ultimate in toasting perfection. Modern streamlined design.
- **New Flexible Timer** automatically compensates for normal voltage fluctuations. Assures perfect, golden-brown toast on every operation.
- **Combination toast selector dial and release** allows choice of perfect toast that's light, dark, or in-between.
- **Handy signal light** on either side to show when either 2-slot section is in operation.
- **Beveled-edge toast slots** provide for fast and easy loading of bread.
- **Convenient crumb tray** slides out easily for cleaning, without moving toaster.

✓ **Heavy-duty construction . . . ruggedly built for years of service.**

✓ **New "Toastmaster"* Powermatic Toaster makes every slice perfect. Serves it up uniformly crisp, golden-brown, appetizing, and delicious.**

✓ **Reduces current waste. Uses current only while toasting and only in slots that are actually at work.**

✓ **Modern streamlined design. Durable finish of heavy nickel and chromium will stay bright for years.**

✓ **Flexibility for the future. Larger models—8, 12, or 16-slice—are composed of "add-on" 4-slice units.**

at your Restaurant Equipment Dealer's.

PRODUCTS

8-Slice Model †$278.00

12-Slice Model †$412.50

16-Slice Model †$556.00

Case history
of CECO on-the-job
performance

How 1,500,000 hospital employees helped make a better door...

Ceco offers hollow-metal doors with engineered hardware . . . built to stand hard use

When Ceco engineers sought to make a better door, they went to the experts on "hard use" for ideas. They observed the wear and tear a door must take from 1,500,000 hospital employees on the move . . . in a hurry . . . rushing in and out.

The result was four owner-wanted benefits, all incorporated in Ceco's new Hollow-Metal Doors:

1. Locksets that won't come loose—because doors are engineered for attaching special Yale hardware through reinforced tapped holes.

2. Hinges that hold tight—doors and frames reinforced.

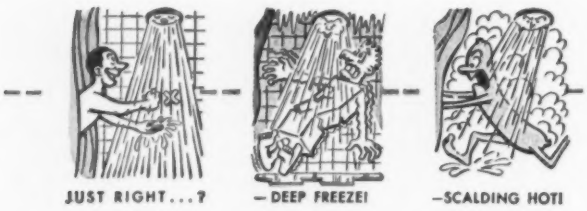
3. Moldings that stay put—locked with drive-in pins.

4. Glazing beads that won't pop out—snugged with screws.

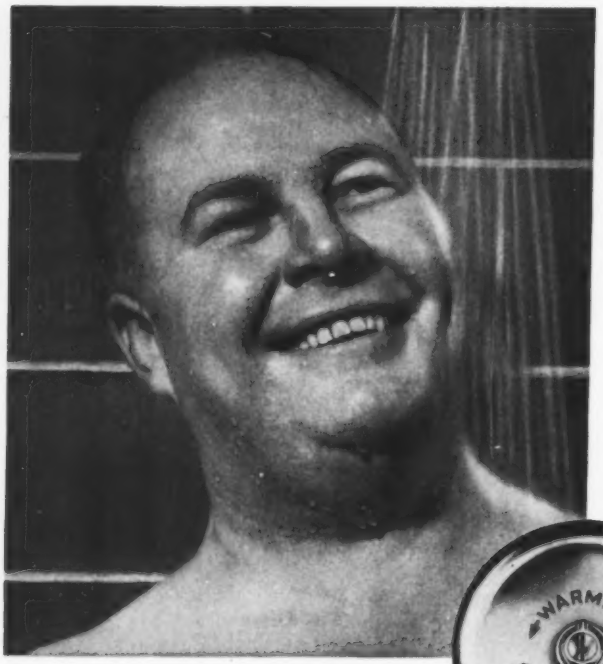
Variations of hand, swing and hardware are supplied from basic stock units . . . high production cuts costs. Put these benefits to work in your next building. Write for catalog 1040-B.

In construction products
CECO ENGINEERING
makes the big difference

CECO STEEL PRODUCTS CORPORATION
Offices, warehouses and fabricating plants in principal cities • General Offices: 5601 W. 26th Street, Chicago 50, Illinois



Public Liabilty Insurance Will Not Protect Shower Users from personal injuries, nor does it, in case of accidents, protect property owners from damaging publicity or time consuming lawsuits.



End Shower Complaints

with

Double-Safety

of

POWERS

Thermostatic WATER MIXERS

They protect bathers from scalding and "shots" of hot or cold water, caused by—

★1 **PRESSURE or**

★2 **TEMPERATURE**

fluctuations in water supply lines

Only a **thermostatic** water mixer gives this **double-safety**

Refreshing, Relaxing Safe Showers
and water economy too, are assured by Powers Thermostatic Water Mixers

One moving part easily accessible from the front. Easy removal of thermostatic motor and valve assembly with only a screwdriver makes it possible to inspect, clean or flush out mixer. Powerful thermostatic motor gives quick, positive shut off if cold water supply should fail.

No Shower Is **MODERN** Without This Protection

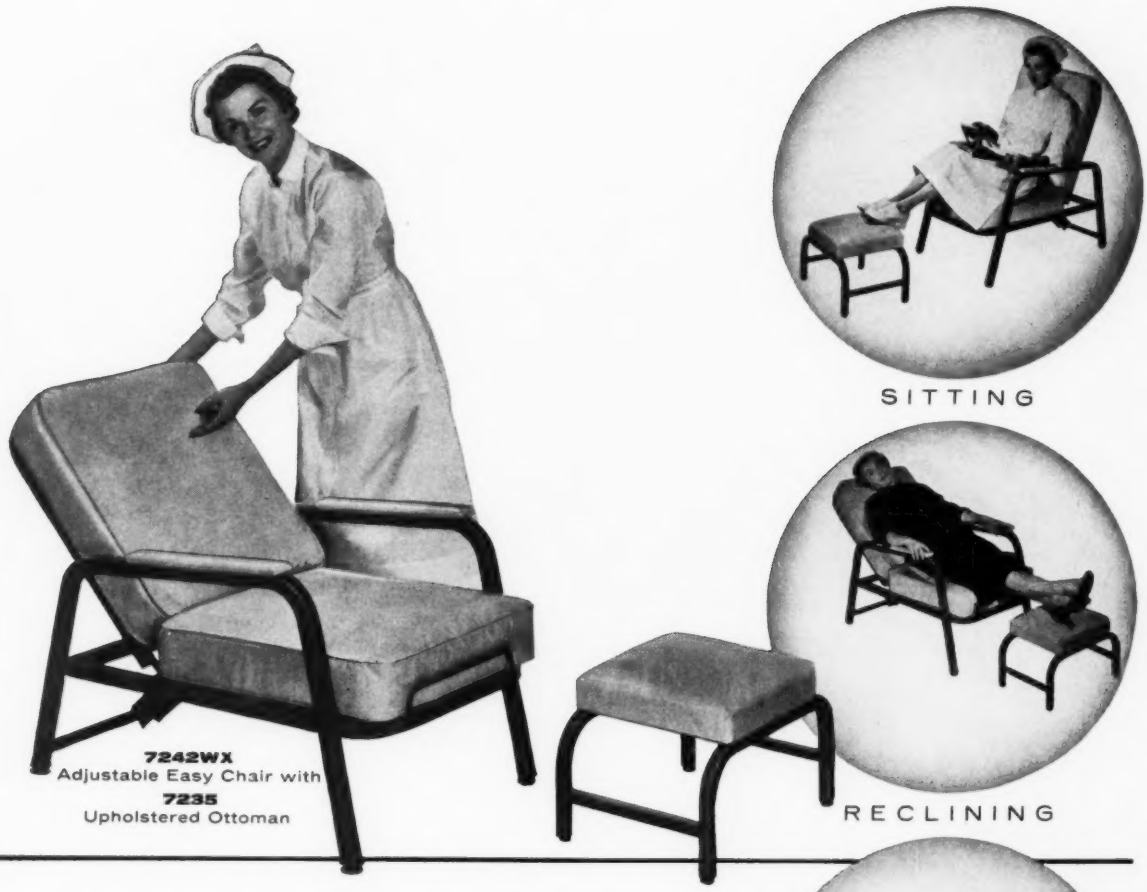
Powers thermostatic water mixers *always* hold shower temperature constant wherever the bather wants it. They are completely automatic. Failure of cold water supply instantly shuts off the shower. Delivery is *thermostatically* limited to 115° F.

POWERS Mixers Save Water. No time or water is wasted by bather having to get out from under shower because of fluctuating shower temperature. Water conservation feature alone makes Powers mixers a profitable investment.

"Minimum of Maintenance" . . . report many users of Powers Type H Thermostatic Water Mixers. Their simple, durable construction insures years of dependable service. (b63r)

For Utmost Comfort, Safety and Economy Install Powers Mixers • Write for Bulletin 365

Established in 1891 • **THE POWERS REGULATOR COMPANY** • SKOKIE, ILL. • Offices in Over 50 Cities



Amazingly Versatile

HARD DUAL PURPOSE ADJUSTABLE EASY CHAIR

A comfortable easy chair that's useful day and night. Adjusts to provide comfortable reclining positions for the patient. Lowers to sleeping position for relative or attendant staying overnight. Saves bringing in and setting up a cot. Extended rear legs make the chair absolutely tip-proof in all positions . . . prevent the back, when in the upright position, from marring room walls. Comfortable innerspring seat and back cushions. Matching upholstered arm rests. Seat cushion retainer. Available in a wide choice of baked enamels, plain and grained finishes, with matching fabric-backed plastic cushion covering.

Sold Exclusively through Hospital and Surgical Dealers

HARD MANUFACTURING CO.
BUFFALO 7, N. Y. FOUNDED 1876

ST. FRANCIS CABRINI HOSPITAL
Alexandria, La.
GOLEMAN & ROLFE, Architects
REG. F. TAYLOR, Mech. Engineer
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SCIAMBRA & MASINO, Inc.
New Orleans, Heating Contractors

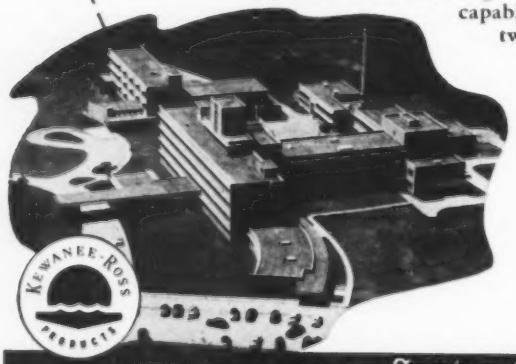
MORE ENGINEERING
MORE MATERIAL
MORE EXPERIENCE

MAKE THE DIFFERENCE

KEWANEE
STEEL BOILERS

The design and equipment of today's boiler rooms often includes provisions for generating both high and low pressure steam as well as provision for future expansion.

In the St. Francis Cabrini Hospital two Hi-Pressure Kewanees and one Low-Pressure Kewanee, for gas firing, were installed . . . providing a battery of boilers capable of producing some 15 million Btu hourly. The two high pressure Kewanees are each rated at 109 hp.

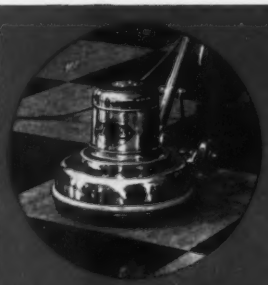


Whether for high or low pressure *more goes into* every Kewanee . . . more engineering, more material and more experience . . . so the *owner gets more from them.* That's why you find Kewanees on the job in America's finest buildings.

KEWANEE-ROSS CORPORATION
Division of American Radiator & Standard Sanitary Corporation
KEWANEE, ILLINOIS

Serving home and industry
AMERICAN-STANDARD • AMERICAN BLOWER • CHURCH SEATS • DETROIT LUBRICATOR • KEWANEE BOILERS • ROSS HEATER • TONAWANDA IRON

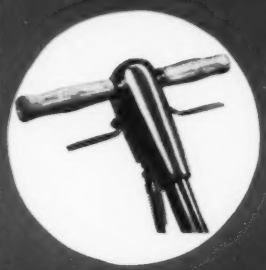
5 GOOD REASONS WHY CLARKE IS YOUR BEST BUY



HEAVY DUTY MOTOR guarantees power to wade through toughest jobs such as steel wooling wet floor seal and disc sanding.

FULLY ADJUSTABLE HANDLE features new handy locking device. Can be locked in vertical position for storage. Self-retracting wheels flip up automatically as weight is shifted to brush.

PRECISION DRIVE features planetary gear system which gives maximum, quiet efficiency in transmitting power from motor to brush.



AUTOMATIC DUAL SWITCH has high overload capacity, rugged housing. Controlled with either or both hands.

WET SCRUBBING at low cost. A Clarke Wet-Dry Vac picks up solution.

ADVANCED DESIGN and construction for long, efficient service. Perfect balance, machine runs itself, operator guides it.

CHECK THESE FEATURES, then put yourself behind a Clarke Floor Maintainer. You'll agree the powerful, streamlined, quiet, easy-handling Clarke has everything it takes to scrub, wax, polish, steel wool, disc sand, grind, safely shampoo rugs, carpets.

Every floor care job is accomplished in a fraction of the time required by ordinary hand methods — physical effort is reduced to a minimum, costs cut to the bone.

You'll see why *your* floors are certain to be clean, easy to keep safe and bright.

Clarke offers several sizes of Floor Maintainers to fit your needs and budget. And, one of six Clarke Heavy Duty Wet-Dry Vacuum Cleaners will complete an unsurpassed cleaning team.

Write for details. Better yet, ask for a demonstration now.

Your copy FREE! *Write today for colorful, 22-page "Your Floors and How to Care for Them."*

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SANDING MACHINE COMPANY

528 E. Clay Avenue — Muskegon, Michigan

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Distributed in Canada:
Clarke Vacuum Cleaners: G. H. Wood & Co., Ltd., P. O. Box 34, Toronto 14, Ont.
Clarke Floor Maintainers: Strongridge Ltd., 124 Weston St., London, Ont.

Announcing

A UNIQUE NEW TOPICAL ANESTHETIC

Tronothane® hydrochloride

(PRAMOXINE HYDROCHLORIDE, ABBOTT)

WITH GREATER SAFETY FROM
SENSITIZATION OR TOXICITY

OBSTETRICS

DERMATOLOGY

PROCTOLOGY

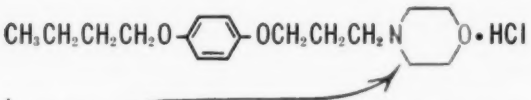
ANESTHESIOLOGY

A NEW APPROACH

TRONOTHANE is a new topical anesthetic created by Abbott Laboratories. It fills a conspicuous gap among anesthetics by combining (a) potent relief from surface pain or sensation with (b) relative freedom from sensitization or toxicity.

NOT A "CAINE"

TRONOTHANE is not related structurally to other anesthetics. Its formula



contains a morpholino radical; this is unique among clinically useful local anesthetics, and serves to reduce toxicity in TRONOTHANE. Note the absence, too, of certain familiar chemical groups, as of the "caine" drugs. Thus cross sensitizations are made unlikely.

LESS SENSITIZING

In comparative tests on 69 adults[3]—much more severe than likely in clinical practice—TRONOTHANE showed only about one-fifth as many sensitization reactions as another widely used topical anesthetic; what TRONOTHANE reactions did occur were moderate.

PROMPT, EFFECTIVE ACTION

TRONOTHANE's anesthetic excellence is amply demonstrated in clinical tests. For example:

FIELD	No. of cases	Good to excellent results	Per cent good to excellent
PROCTOLOGY[1]	100	[illegible]	92
OBSTETRICS[2]	325	[illegible]	80
ANESTHESIOLOGY[3]	199	[illegible]	93
DERMATOLOGY[4]	185	[illegible]	93

Typical uses include relief of discomfort in episiotomy, cracked nipples, hemorrhoids, anal fissure, anogenital pruritus, itching dermatoses, certain intubation procedures, and minor burns or trauma. *Professional literature is available on request from Abbott Laboratories, North Chicago, Illinois.*

Abbott

1. Peal, L., and Karp, M., A New Surface Anesthetic Agent: TRONOTHANE, Anesthesiology, in press, 1954.
2. White, C. J., A New Anesthetic for Certain Diseases of the Skin, J. Lancet, 74:98, March, 1954.
3. Schmidt, J. L., Berryman, G. H., McAndrew, M. J., and Richards, R. K., Unpublished data, Abbott Laboratories, 1952.
4. Schwartz, F. R., TRONOTHANE in Common Pruritic Syndromes. Postgrad. Med., in press, 1954.
5. Birnberg, C., and Horner, H., A Simple Method for the Relief of Postpartum Perineal Pain, Amer. J. Obst. & Gynec., 67:661, March, 1954.

408183

"TRONOTHANE is an excellent anesthetic agent with minimal sensitivity."[3]

"Quite different from other local anesthetics...this may make it a valuable agent for the treatment of individuals who are sensitive to topical agents."[4]

"TRONOTHANE provides a desirable combination of properties—low toxicity, low sensitization, and structural individuality, together with prompt and adequate anesthetic effect."[4]

"Its action was prompt...No instance of cross sensitivity to TRONOTHANE was encountered in patients who were reported to be sensitive to other topical anesthetic ointments."[5]

TOPICAL SOLUTION, 1%, 15 cc. Sterile, not for injection.

beyond question-

like a proved formula

$$CH_2(COOC_2H_5)_2 + ClCH_2COOC_2H_5 + C_2H_5ONa = CH(COOC_2H_5)_2 \cdot CH_2COOC_2H_5 + C_2H_5OH + NaCl$$

Precision
FREAS*

Model 120—1 of 45 models available

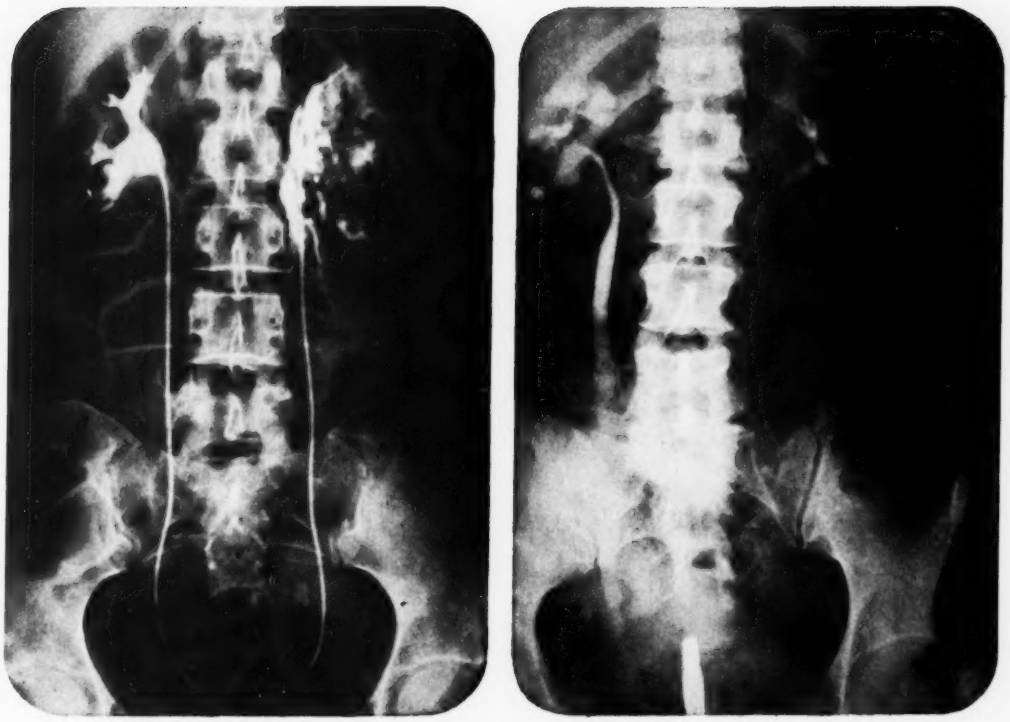
For more than 40 years laboratory people have been justified in relying on Freas. During many of these years we were unable to produce Freas units as fast as they were called for. Now, after notable expansion, we can ship most models from stock. Freas *quality,* far from being compromised, has actually been improved.

**Ask your laboratory supply dealer about Freas ovens, incubators or sterilizers.*

Write for
CATALOG 331A

Precision Scientific Company
3735 West Cortland Street — Chicago 47

Specify FREAS First . . . . to Last



SHARP SHADOWS SHOW MORE *Uniform*

Skiodan mixes readily and uniformly with urine and is as nonirritating as physiologic saline solution. No local or systemic reactions have been observed even when Skiodan was retained in a hydronephrotic sac or extravasation occurred in ruptured bladder cases.

Skiodan gives a well defined, sharp and clear delineation of the upper urinary tract. It is also valuable for uniformly clear cystograms and urethrograms — without the danger of embolism inherent in oily substances.

SUPPLY: Solution 40 per cent (50 cc. and 100 cc.). Solution 20 per cent (50 cc.). Tablets of 1 Gm. (100s and 500s).

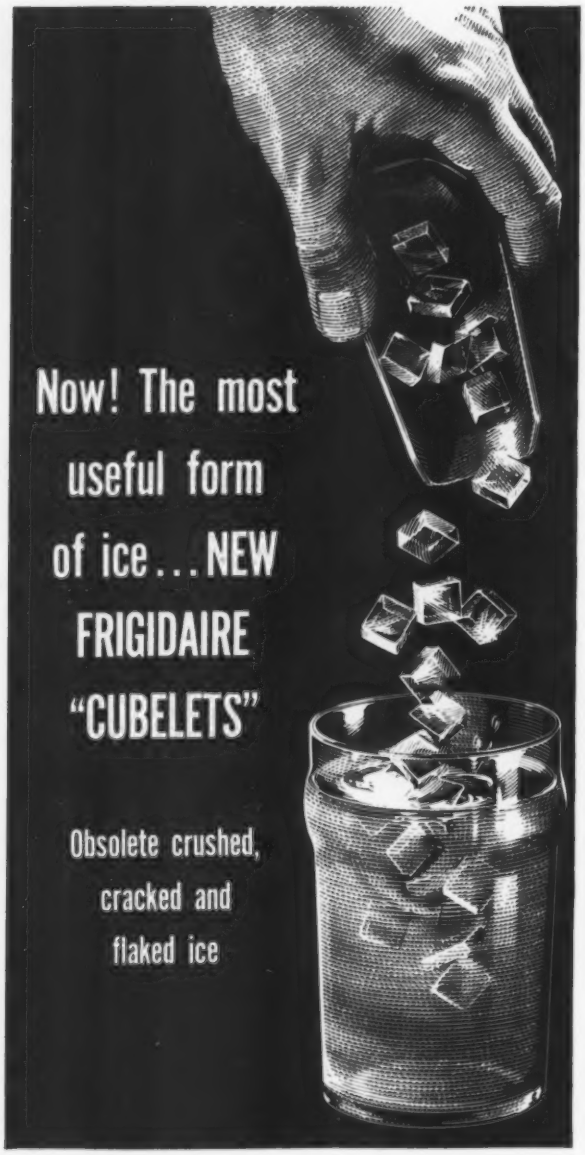
WINTHROP

WINTHROP-STEARNS INC.
New York 18, N. Y. • Windsor, Ont.

SKIODAN® SODIUM

NO IRRITATION
Retrograde Pyelography
WELL DEFINED

Skiodan, trademark reg. U.S. Pat. Off., brand of methiodal



Frigidaire's sensational new "Cubelet" Makers are ideally suited for use in hospitals. They produce an entirely new and better kind of ice . . . "Cubelets" . . . only ⅝" square, thick or thin as desired . . . tiny, clear, sanitary gems of ice, purer than the water they're made from. Far superior to unsanitary, fast-melting crushed ice and sharp, jagged flaked ice, they are ideal for cool drinks, ice water, ice packs, food service and many other hospital needs.

The Frigidaire Ice Cube Maker is attractively styled. Only 44¼" long; 31½" deep; and 38⅝" high. Handy flat top serves as extra work area. Available in two models—for "Cubelets" or regular size ice cubes. Both units are powered by the Frigidaire Meter-Miser, warranted for 5 years. Call your Frigidaire Dealer. His name is in the Yellow Pages of your phone book. Or write: Frigidaire, Dayton 1, Ohio. In Canada, Toronto 13, Ontario.

Frigidaire Ice Cube Makers

BUILT AND BACKED BY GENERAL MOTORS

HOSPITALS COAST TO COAST USE FRIGIDAIRE ICE CUBE MAKERS

Pass rigid sanitary and health codes

The Chestnut Hill Hospital, Philadelphia, Pa., is one of the many modern, up-to-date hospitals now using Frigidaire Ice Cube Makers for quick, sanitary ice service. It is a typical example of the way progressive hospitals, coast-to-coast, are eliminating the mess, waste, and unnecessary labor connected with a centrally located ice source, by installing Frigidaire Ice Cube Makers.

Super-simple operation

Spotted at convenient locations throughout the hospital, they save nurses' and attendants' time, permit quicker service, cut wasteful melting and—most important—produce purer, clearer, more sanitary ice untouched by human hands.

Only the Frigidaire Ice Cube Maker offers really carefree, trouble-free service. Operates with utmost simplicity. A sheet

Makes up to 200 pounds a day

of ice is formed by circulating water. When this sheet attains desired thickness, it slides by gravity onto electrically warmed grids that cut it into regular size cubes or tiny "cubelets". These are solid, crystal-clear, uniform and mineral-free. There are no grinders, choppers, chains or knives to get out of order, cause breakdowns or make noise. Produces up to 200 lbs. of solid cubes for as little as 26¢ a day . . . automatically! You merely open the bin and scoop out the cubes you need. No trays to fill or empty, no tanks to fill or clean.

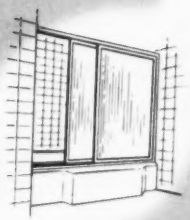
Chestnut Hill Hospital, Philadelphia

LUDMAN
Auto-lok
AUTOMATIC LOCKING
PATENTED

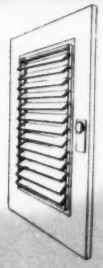
AUTO-LOK
ALUMINUM
AWNING WINDOWS

AUTO-LOK
HOPPER VENT
WINDOW

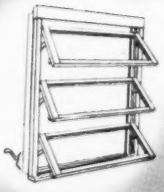
AUTO-LOK
CONTROL BAR
WINDOW



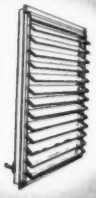
SHOWER DOOR
TUB ENCLOSURES



JALOUSIE DOORS



AUTO-LOK
WOOD
AWNING WINDOWS



JALOUSIES

in all the world....products by

LUDMAN
have no equal!

Wherever you go—all over the world—you'll find LUDMAN the foremost name in awning windows, jalousies and shower door tub enclosures. LUDMAN'S advanced design, engineering skill and unrivaled craftsmanship have earned for its products an enviable reputation for high-standard quality.

LUDMAN products are produced in the largest plant of its kind in the world .... where complete quality control is maintained from raw material to finished products.

In value, in quality, in performance, in exclusive features .... Ludman products have no equal!

REFER TO SWEET'S FILE
MEMBER OF THE
PRODUCERS' COUNCIL, INC.

LUDMAN *Corporation* **NORTH MIAMI, FLORIDA**

world's largest manufacturer of awning windows, jalousies and tub enclosures

WE'VE DONE RESEARCH TOO!

Ludman, the world leader in window engineering, as a result of years of scientific research and study of hospital windows problems has developed, with its patented Auto-Lok principle, a number of applications designed to answer every hospital window requirement.

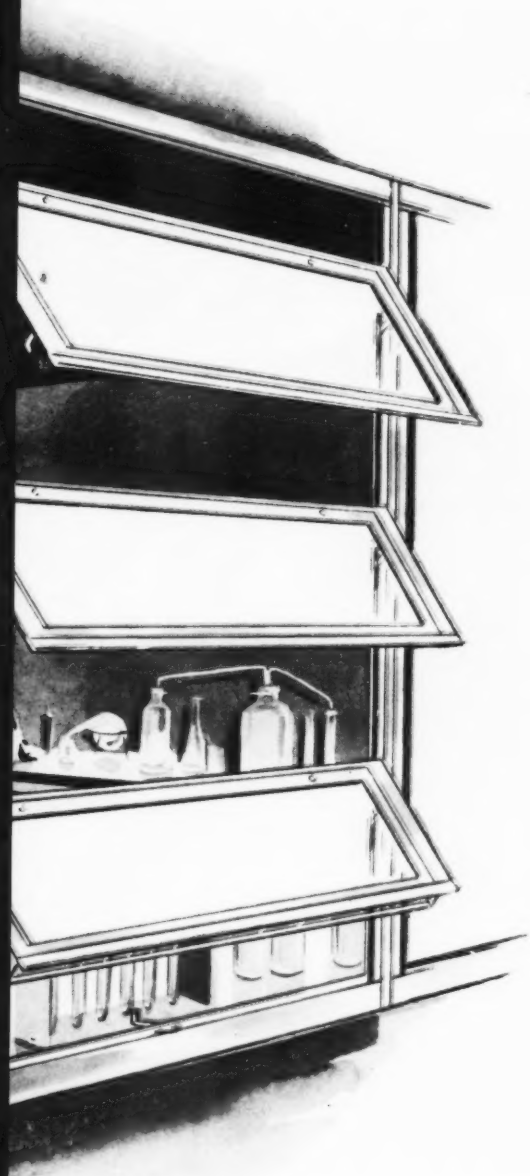
Regardless of what model Ludman patented Auto-Lok window you use, you may be sure that each Ludman Window . . . . and only Ludman Windows . . . . will have all ten features that experts* agree are important in a window. These features are particularly important in hospital windows.

Both hospital boards and architects agree that Ludman patented Auto-Lok windows are unequalled for hospital use. Hospital boards insist on Ludman patented Auto-Lok windows because of low maintenance economy . . . . lifetime trouble-free operation . . . . vandal protection . . . . instantaneous window control. No other hospital window can close so tight . . . . lock so securely . . . . seal so completely against loss of winter heat or summer air conditioning. Ludman patented Auto-Lok windows can't rust or rot . . . . have no wearing parts . . . . need no adjustment ever. Product of the world's largest manufacturer of awning windows and jalousies, Ludman patented Auto-Lok windows are 100% quality control from raw material to finished window in the largest plant of its kind in the nation.

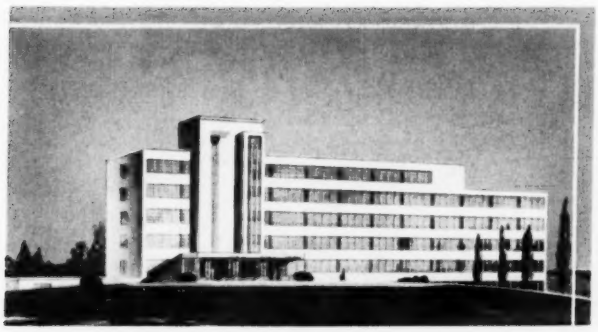
Leading architects prefer to specify Ludman *patented* Auto-Lok Windows because they are adaptable to any type of architectural design.

Many hospital installations throughout the nation have proved the wisdom of the hospital board and architect's selection of world-famous Ludman *patented* Auto-Lok windows, the tightest closing windows ever made.

*Geoffrey Baker and Bruno Funaro in "Windows in Modern Architecture."



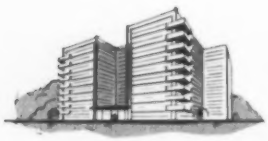
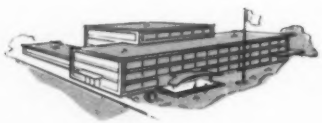
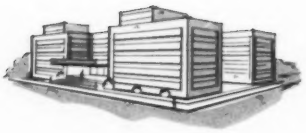
Ludman, World leader in window engineering, has developed the tightest closing hopper vent window ever made. The Hopper Vent can be used with the Ludman patented Auto-Lok Control Bar Window and the Standard patented Auto-Lok Window.



MANATEE VETERAN'S MEMORIAL HOSPITAL, Bradenton, Florida.
Architects & Engineers: Bail, Horton & Associates, Contractor: Larsen Brothers

BURLINGTON PROTESTANT HOSPITAL, Burlington, Iowa.
Architects: Morgan-Gelatt & Associates, Contractor: Carl A. Nelson & Co.

CITY HEALTH CENTER, Toledo, Ohio.
Architects: Peterson, Hoffman & Grow, Contractor: A. C. Bentley & Sons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AUTOMATIC LOCKING — PATENTED

SEALS TIGHTER THAN A REFRIGERATOR

MEETS WHAT EXPERTS* AGREE ARE THE 10 MOST IMPORTANT REQUIREMENTS IN A WINDOW!

The Ludman Corporation maintains a complete research and engineering department, and is always happy to provide counsel regarding any window problems.

Your local Ludman representative can help you determine your special requirements for your particular installation. He can also advise you on standard applications and give you estimates at no cost

Mail this coupon today for illustrated literature showing various styles and sizes and product information.

1. AMOUNT AND QUALITY OF VENTILATION?

100% draft-free ventilation, because sash open to almost 90° and entering air is always scooped inward and upward into the room.

2. POSSIBILITY OF CONTROL OF VENTILATION?

You make your own weather! Perfect control in all positions from a slight crack of one sash to a full 100% opening of all sash.

3. IS THE WINDOW EASILY OPERATED?

Effortless opening and closing assured for the life of the building because of fingertip action roto-operator and friction-free, precision balanced *patented* AUTO-LOK hardware. A few simple turns completely opens or closes every *patented* AUTO-LOK window regardles of size! *Patented* AUTO-LOK windows never stick.

4. WEATHER PROTECTION WHEN THE WINDOW IS OPEN?

With *patented* AUTO-LOK you can enjoy the luxury of healthful, refreshing ventilation during rains.

5. WEATHER-TIGHTNESS WHEN THE WINDOW IS CLOSED?

Patented AUTO-LOK IS THE TIGHTEST CLOSING WINDOW EVER MADE.... many times tighter than any other window. *Patented* self-locking device plus "Floating Seal" weatherstripping automatically seals the window tight and isolates weather to a degree heretofore believed impossible.

6. WHAT OBSTRUCTIONS TO VIEW (RAILS AND MUNTINS)?

Beautiful exceptionally narrow sight lines are retained. *Patented* AUTO-LOK meets any architectural or design requirement in this respect. Concealed hardware eliminates unsafe, unsightly, dirt collecting, exposed mechanism.

7. FIRST COST?

Thanks to Ludman's streamlined methods, *patented* AUTO-LOK windows cost no more, than ordinary old-fashioned windows. You cannot buy better window performance at any price.

8. MAINTENANCE COSTS?

Simplified operation eliminates wearing parts; no periodic adjustments necessary. Ludman engineering leadership combines the best in design, the best in material and the best in workmanship to make a window that will perform for the life of the building with a minimum of maintenance.

9. CAN ALL WINDOW GLASS BE CLEANED FROM INSIDE?

Patented AUTO-LOK can be completely, comfortably and conveniently cleaned entirely from the inside. No gadgets to disengage; no sash to remove. Just open the window and it's ready to clean—top sash too!

10. HOW DOES THE WINDOW FIT IN WITH PLANS FOR SCREENS, STORM SASH, BLINDS, ETC.?

Interchangeable, inside screens and storm sash are easily placed and removed. Just flip the clips.... no tools required! Operator does not protrude into room. No interference to drapes, blinds, etc.

Geoffrey Baker and Bruno Funaro in "Windows in Modern Architecture"

LUDMAN CORPORATION, Dept. 00, North Miami, Florida

Gentlemen: Please send complete information about these Ludman products:

- ☐ WOOD AWNING WINDOWS
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LEADS THE WORLD IN WINDOW ENGINEERING

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Polar Pan-ette
a scaled-down bedpan of stainless steel

The lower height — over an inch less lift — makes this scaled down model especially recommended for oldsters, youngsters and fracture cases.

fully adequate for most patients, more comfortable for all patients . . . and it costs less to buy.

You don't order only large-size patient gowns just because these are sure to fit everybody—then why buy only *big* bedpans when the overwhelming majority of patients will be much more comfortable using a smaller pan that adequately meets every requirement.

So it is that Polar Ware makes the PAN-ETTE, smaller in all dimensions but just as long in service life. Seamless in design, it's made from heavy gauge stainless steel, highly polished on the outside, with a satin smooth interior finish. And because the PAN-ETTE is reduced in size, it's also reduced in cost — offers you a very solid saving.

Ask the supply-house men who call on you for the happy facts. You'll find the best of them carry Polar Ware.

In ordering the PAN-ETTE specify No. S-00 bedpan.

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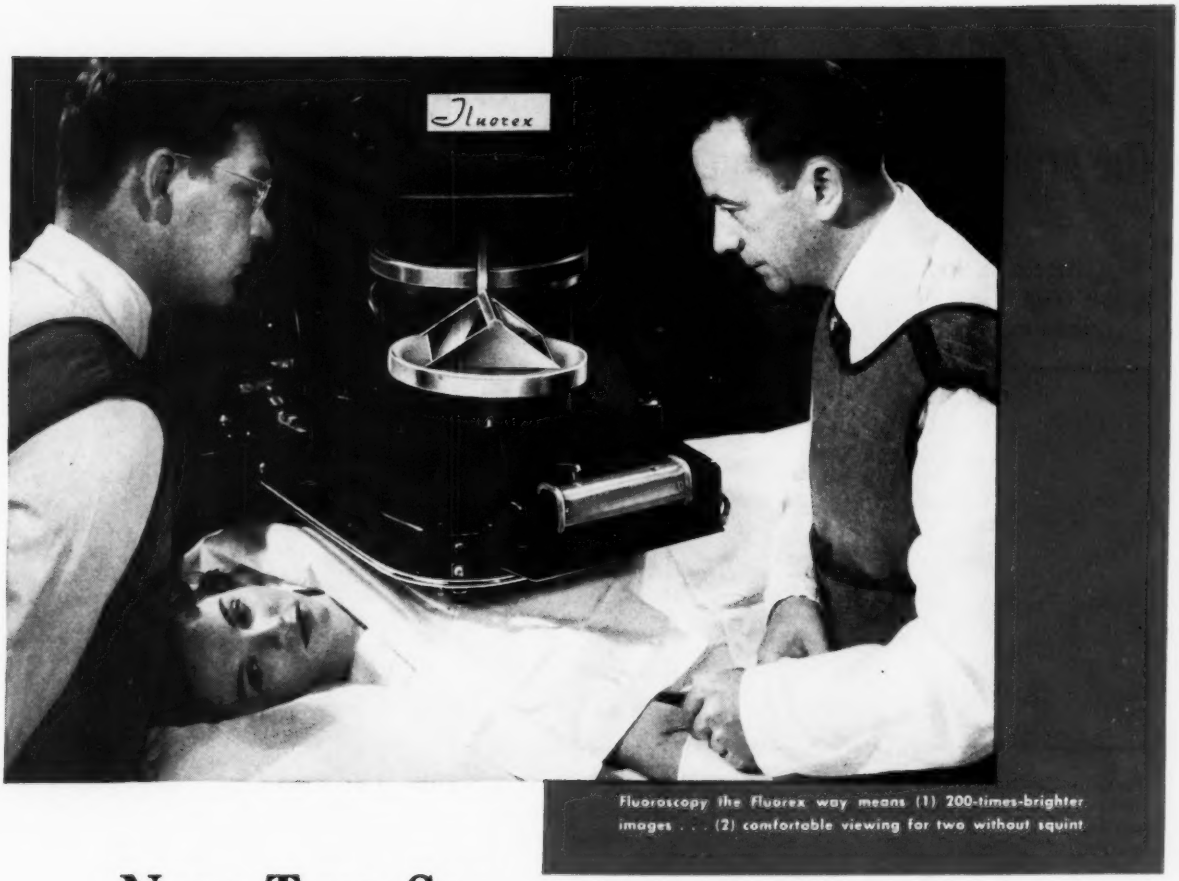
Merchandise Mart — Chicago 54 Room 1100-1101 | *123 S. Santa Fe Ave. Los Angeles 12, California | *415 Lexington Ave. New York 17, New York | *Designates office and warehouse. Offices in Other Principal Cities



Fluoroscopy the Fluorex way means (1) 200-times-brighter images . . . (2) comfortable viewing for two without squint

Now Two See Brighter Images—Simultaneously—with Westinghouse Fluorex

This double-view mirror accessory for the Westinghouse Fluorex Image Amplifier brings new convenience to many fluoroscopic examinations. Two individuals can now observe details of fluoroscopy simultaneously, and in both-eyes-open comfort.

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For two viewers, or one, Fluorex brightens images. Delineation is significantly sharper even in partially lighted rooms. Time required for dark adaptation is reduced since cone vision is used. Call your Westinghouse X-ray representative or write to the address below.

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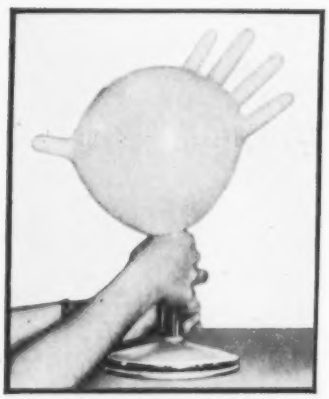
NOW— *new ease, new efficiency in testing and powdering surgical gloves!*

The brand new McKesson Glove-Testing and Powdering Equipment

Nurse or assistant sits up to table, same as a desk.

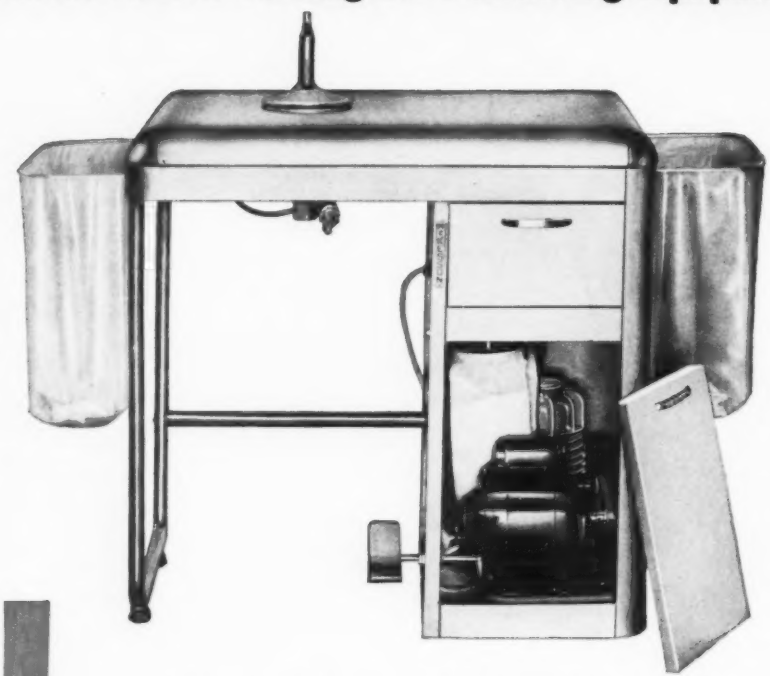


Press toe down on top of treadle and ¼-horsepower compressor inflates glove to desired size in matter of moments, spraying powder clear to fingertips at same time.

Each finger may be inflated for special precaution or to doublecheck on possible flaw.

Gloves to be tested are placed in plastic detachable bag at left side of Unit. Tested gloves are dropped in bag at right. Adjustable control assures precise amount of powder needed. Gloves are then ready for sterilization.

Ease and efficiency at its best! Faster, more economical, more uniform! A sure way to eliminate the tiniest flaw!



Operation and Details of McKesson Glove-Tester

Powder or starch-base material is loaded into powder container from top of equipment, simply by removing container cover . . . Three positions on treadle control—down to inflate, half-way up to hold inflation, heel down to deflate . . . On deflation, powder exhausts back into powder container, and any excess powder in exhaust line is trapped by vacuum-cleaner-type bag installed in compressor compartment . . . Powder and supplies are stored in deep utility drawer at top . . . Top of plastic bags slips into sturdy, chrome-plated steel band, the ends of which fit into firm sockets. Bags are easy to install and remove . . . Top and fittings are of stainless steel. All fittings chrome-plated. Rest of equipment of Silverlite hammer-finish.

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GLOVE-TESTING AND POWDERING EQUIPMENT

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Easy as answering the phone!

NURSES LEARN IN NO TIME FLAT...

STANDARD Royal

Specify ROYALMATIC

Hospital Communications Systems

NO MORE "ERRAND BOY" DUTIES *for highly trained nurses. The majority of patients' calls need only a single reply by phone. With* ROYALMATIC, *the nurse can answer from any place. Think of the weary miles of walking this cuts out!*

SIMPLICITY ITSELF . . . AUTOMATIC SELECTION *of calls when you install* ROYALMATIC . . . *no switches — no "press-to-talk" . . . automatically cancels calls when nurse hangs up . . . leaves them free for more important duties. Can take calls anywhere — in utility room, diet kitchen, where-have-you — by simply installing hand phone sets in these rooms.*

NIGHT SERVICE HOOK-UP . . . *Nurses answer any patient's call from any phone on any floor . . . eliminates duplication, expensive equipment and costly wiring.*

Hospitals, with today's acute shortage of Nurses, are rapidly installing ROYALMATIC Systems with their audible-visible, automatic answering and dual reset features. ROYALMATIC is the ultimate in nurses' call systems.

When you install ROYALMATIC you not only stretch your nursing personnel, but your operating dollars — often up to 63% when you reckon all forms of saving.

STANDARD-ROYAL Hospital Communication Systems give you better, faster patient service, increase your efficiency and cut your costs . . . in a word, give you brand new hospitals for old. It will pay you, as it has so many others, to get in touch with us and *Bring Your Hospital Up to Standard.*

The STANDARD ELECTRIC TIME COMPANY

69 Logan Street, Springfield 2, Massachusetts

Gentlemen:

Kindly send me further information ☐

I would like an interview with one of your experienced hospital communications specialists ☐

NAME_____ TITLE_____

COMPANY_____

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CITY_____ STATE_____

Aid patient recovery with the new Honeywell Round!

NOW–A NEW THERMOSTAT SYSTEM

In room 204, this patient is well on her way to recovery from minor surgery. Her doctor felt that a temperature of 75° would contribute most to her sense of well-being. This is easily possible because of the Honeywell Hospital Thermostat installed right in her room.

In room 304, the patient suffered extensive skin burns, and his physician prescribed a room temperature of 67° to accelerate heat loss from the unaffected skin areas. This medical practice of prescribing temperatures is possible only with a thermostat in every room.

Individual Room Temperature Control now possible . . . room by room . . . to fit your budget

HERE'S a *simple* new thermostat system—the Honeywell Round—that can be installed in your present hospital for as little as $350.00 for 4 rooms.

Start *right away* with the Honeywell Round—have it installed in any heating "trouble spots" you may have. Then, as your budget permits, you can have it installed room by room throughout your hospital.

Installation of the Round is *easy* . . . you don't have to tear up floors or walls . . . *you don't even have to redecorate.* Tiny, simple wiring is used with a Honeywell automatic radiator valve and a miniature transformer.

Today physicians and surgeons in many modern hospitals prescribe *exactly correct* room temperatures to help speed patient recovery. But this medical practice is possible *only with a thermostat in every room.*

This is the only method that can compensate for the varying effects of wind, sun, open windows, and other temperature factors in each room.

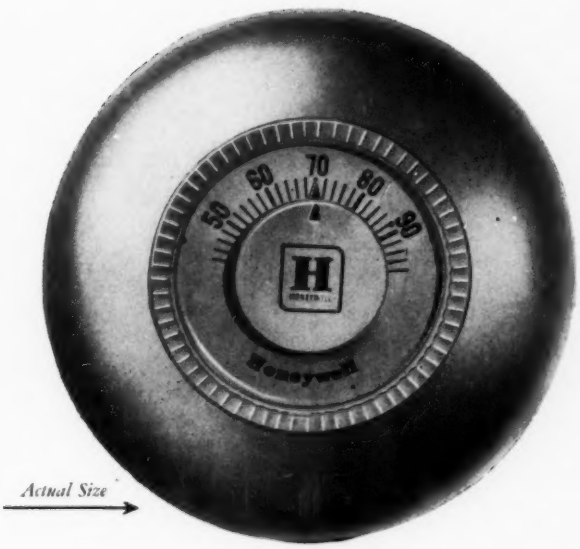
This Honeywell Round system is especially designed for existing hospitals. But whether you're modernizing your hospital or building a new one, Honeywell has the Hospital Thermostat system to suit your particular needs.

Just call your local Honeywell office for complete information. Or, write to Honeywell, Dept. MH-8-158, 351 East Ohio Street, Chicago 11, Illinois. Ask too for your copy of the new booklet "Does this happen in your hospital?"

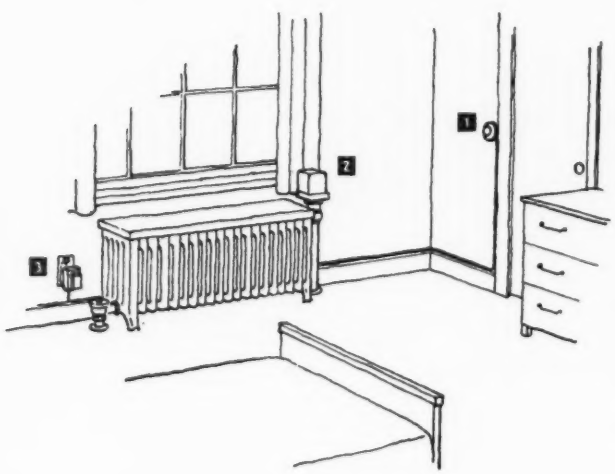
LOW-COST ROOM FOR EXISTING HOSPITALS

The new Honeywell Round features . . .

- **An easy-to-read dial.**
- **Economical installation—*no* redecorating necessary.**
- **Tamper-proof protection—settings and cover can be locked in place.**
- **Sealed, lint-proof mechanism—insures maintenance-free, dependable operation.**
- **Smart appearance—cover can be painted to blend with any color scheme.**
- **Versatility—can be used with *any* type heating system or window type cooling unit.**



Actual Size



The sketch at left shows how easily the Honeywell Round system can be installed in individual rooms in *your* hospital. The attractive thermostat **(1)** blends with the wall . . . it's connected to a Honeywell automatic radiator valve **(2)** and a miniature transformer **(3)** by a tiny wire. It's just as simple and economical as it sounds!

MINNEAPOLIS **Honeywell**

Hospital Temperature Controls

112 OFFICES ACROSS THE NATION

Any way you look at it—
CASTLE STERILIZERS excel

STEAM FLOW MECHANICALLY DIRECTED—entering at central point of backhead, steam is deflected upwards, forwards and downwards to bottom of chamber. This method of forced air evacuation insures uniform penetration of the load and elimination of all air pockets.

SELF-CENTERING SAFETY DOOR—designed to prevent premature opening even when extreme low pressures of 1 lb. or less exist in the chamber...a most simple mechanism.

THERMATIC SYSTEM—that provides to the degree of automatic operation desired, the functions of visible timing, automatic recycling, electromatic operation of valves, impounding of load for full exposure period, remote control.

VISIT THE CASTLE EXHIBIT AT LEADING HOSPITAL MEETINGS AND SEE WHY CASTLE STERILIZERS *consistently steal the show.*

***WRITE TODAY** for complete literature and specifications.*

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Castle **LIGHTS AND STERILIZERS**

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These new Kimble Pipettes combine Kimble quality with new efficiencies. Their new design prevents the cotton plug from slipping down into the main body.

The constriction is large enough for easy cleaning and in no way weakens the tube; nor does it alter flow characteristics.

You can order these new Kimble Pipettes from your hospital supply house, or write to us direct for a free copy of our latest catalog and price listing.

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They are legible—
All markings are clearly indicated with Kimble permanent, *fused-in* filler.

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Each pipette is tested during manufacture, then individually retested for accuracy before shipment.

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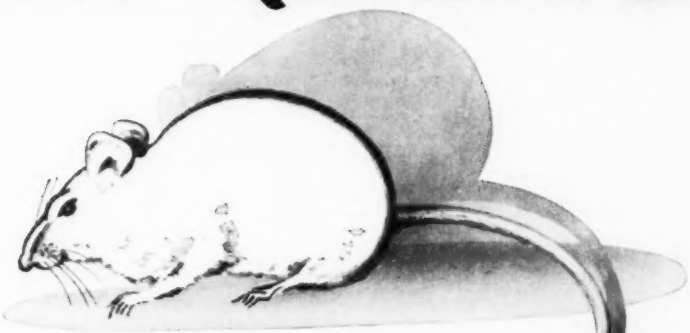
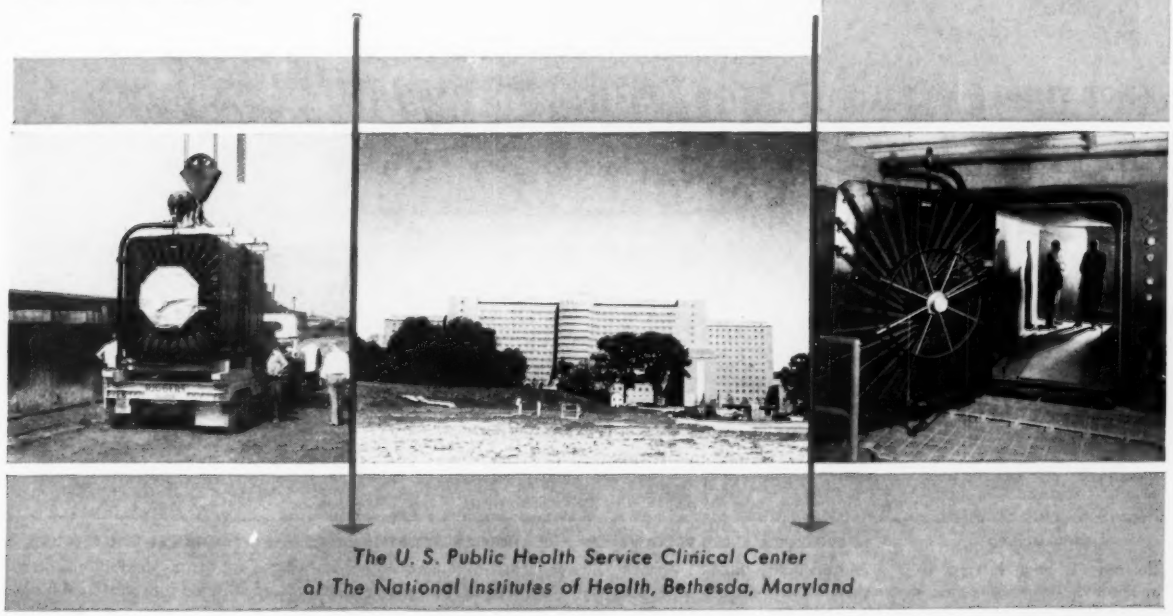


Strange as it may seem, there's a definite relation between the largest sterilizers we've ever built, the National Institutes of Health, and medical research. These huge sterilizers are used in this Clinical Center for the sterilization of equipment and supplies used in animal experimentation which forms a vital part of research studies conducted in the interest of human welfare. These sterilizers were especially designed and built to conform to the Institutes' requirements. Another example of how American can supply special equipment to meet the needs of hospital, research laboratory or industry, using this type of equipment for either routine or special applications. Our research and engineering departments are at your service—no obligation.



The U. S. Public Health Service Clinical Center at The National Institutes of Health, Bethesda, Maryland

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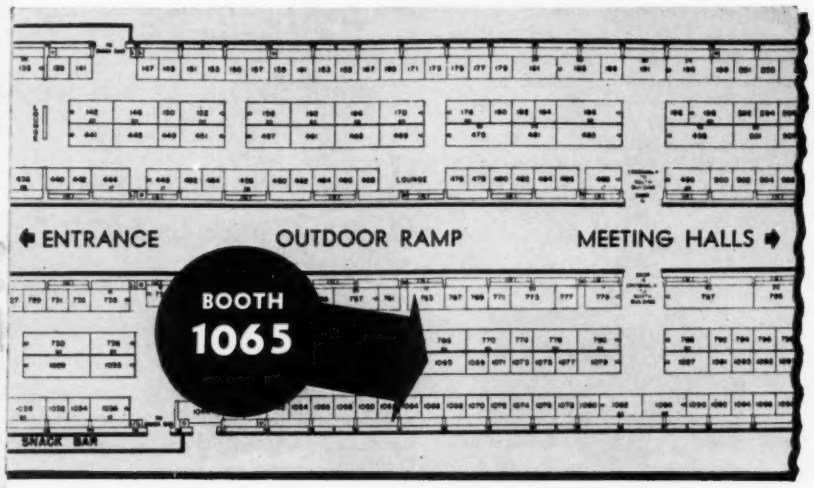
AT THE AHA SHOW..... Look at COUCH-CALL

and See the Difference



HERE'S WHAT TO LOOK FOR:

LOOK at COUCH-CALL's fully automatic operation . . . no switches to throw, no buttons to press. The nurse is immediately and automatically connected to the station calling.

LOOK at COUCH-CALL's complete flexibility. Three types of answering stations, any number of which may be used at convenient locations in the nursing section.

LOOK at the COUCH-CALL room stations operated by a slight pull on the cord. They are equipped with a combination speaker-mike and pilot lights to let the patient know when his call is registered and when the talking circuit is open.

LOOK at the automatic reset feature on all room stations which eliminates many trips on the part of the nurse.

LOOK at COUCH-CALL priority stations which produce an insistent audible signal, flash all lights and override all regular calls. For use in areas where calls may demand immediate personal attention.

LOOK at COUCH-CALL's rugged simple telephone-type construction.. . . . assurance of low maintenance service for years to come. If you're not going to the Show . . . write for Bulletin 126.

Simplified Systems of Communication

S. H. Couch Company, Inc.

Private telephones for home and office . . . hospital signaling systems . . . apartment house telephones and mail boxes . . . fire alarm systems for industrial plants and public buildings.

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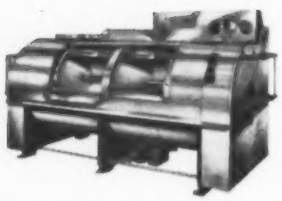
In Canada: Canadian Marconi Company, Montreal.

Why buy 1/2 a Washer?

The American R.H.P. Cascade gives you both halves of the washing job . . .

① *Thorough Open-Pocket Washing*
② *Easy, Faster Unloading*



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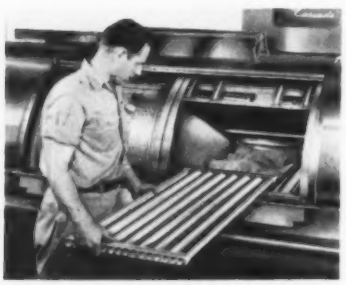
R. H. P. CASCADE

. . . . the labor-saving, money-saving Washer!

Cascade open-pocket washing gives your wash load *full-drop* action—speeds up the entire washing cycle! And American R. H. P.—removable horizontal partitions—save work, cut load removal time!

For the best washing action, with limited equipment cost, the American R. H. P. Cascade is the Washer for you!



Removable horizontal partitions of light-weight, rust-proof aluminum, are easily inserted after load is washed.

Washed work slides from the horizontal partitions . . . no stooping or reaching, unloading is easy and fast.

You can depend on your American Representative. Rely on his advice in your selection from the *complete American Line* of equipment he represents. With our many years experience in planning and equipping laundries, he can help solve your production problems. Ask for his specialized assistance anytime . . . no obligation.

Write for Bulletin AB 330-602. Or call in your American Man . . . soon!

AMERICAN
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

World's Largest, Most Complete Line of Laundry Equipment

Small Hospital Questions

"Markup" on Materials

Question: What is a safe method to use to arrive at a proper charge for consumable materials such as dressings, casts, appliances? How much should be added to our cost price to cover expenses?—J.W.C., Idaho.

ANSWER: It is difficult to arrive at a reasonable and adequate "markup" on every single item consumed in rendering service to hospital patients. Only a detailed cost analysis of your own operation could point the way to fixing proper charges for these items. Many hospital authorities, however, feel there should be no separate charge for such things as dressings, casts and other standard consumable items. Rather, it is felt, the daily room charge should be high enough to cover the cost of these and similar materials. The addition of numerous small charges for minor drugs, dressings and other consumable supplies takes too much time in the accounts receivable department, and the appearance of a multiplicity of such items on the patient's bill is often resented. Generally speaking, it may be wiser to determine how much this kind of material costs per patient per day, then advance the room charge to all patients to cover this cost.

Discounts Discouraged

Question: Do hospitals make purchases for or sell storeroom supplies to their employes? If they do this for any employes, is it confined to any special group? How much markup is added to the cost of items to cover the hospital's cost of handling this procedure? In your opinion is this a desirable practice?—B.T., Ill.

ANSWER: Checks over the last four or five years would indicate that fewer and fewer hospitals are making purchases for or selling storeroom supplies to any of their employes. When this practice is carried on it is customary to mark up from 10 to 15 per cent over the cost of the supply to cover the hospital's cost of handling this type of procedure. It is my opinion that this is a most undesirable practice. Hospitals should be paying their employes salaries and wages at the same level as are paid by other industries and businesses in the area for jobs of comparable responsibility. When this is done, there should be no need to sell anything to employes purchased through the hospital at a discount. Hospital employes should buy their things through regular commercial sources as do all other people in the community.—E. W. JONES.

Don't Charge for Bills

Question: We have an increasing number of patients with insurance. Many have two, some as many as three and four kinds of insurance. This consumes much of our office time filling out forms and making itemized copies of bills. Should a charge be made to the patient for this service? We feel we should make some charge but do not know how much this should be. What are other hospitals doing?—J.P.B., Mo.

ANSWER: It is not customary for hospitals to charge the patient anything for giving itemized copies of bills or filling out standard insurance claim forms, though it is true that some hospitals have instituted a charge of from 75 cents to as much as $2 for this service. However, the experience of these hospitals has been that patients, as well as the insurance companies and Blue Cross plans involved, are dissatisfied when any such charge is levied against them. Therefore, it would seem wiser to consider this service as part of the hospital's regular administrative overhead, and make certain the room charge is high enough to cover the cost of this clerical work. Of course, if you have to furnish a whole transcript of the medical record for an insurance company, an adequate charge for this special service should indeed be made.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

"Returns" Are Bad Business

Question: Is it true that because a great many hospitals make excessive returns of things they buy all hospitals have to pay from 3 to 5 per cent more for all the things they purchase? If so, how can the purchasing agent minimize this bad practice?—D.E.H., Iowa.

ANSWER: I have visited the returned goods department of several national and local hospital equipment and supply dealers and have been amazed to see the tremendous amount of material returned. Many times this material is returned with no authorization from the supplier and no explanation whatsoever as to why it was returned. Investigation in a considerable number of hospitals indicates that too often there is great laxity in the hospital from the standpoint of proper receipt and inspection of goods when they are first delivered to the hospital. Often goods are damaged by the common carriers and the hospital fails to make any claim at all on the railroad or trucking company but simply sends the material back to the supplier. This, of course, is inexcusably bad business practice, as the claim should have been made on the carrier at the time the goods were received.

Another bad practice is that a hospital, through faulty purchasing, is greatly overstocked on certain items. After some of these items have been in stores for six months to a year they deteriorate. The hospital then returns this material to the supplier without explanation or authority.

Certainly it is the job of the hospital administrator and the purchasing agent to see to it that every hospital sets up sound businesslike practices in its purchasing, receiving and inspection and stores department. It seems too bad that those hospitals that do carry on this work properly are penalized in the form of higher prices because a certain percentage of hospitals do not seem to know how to conduct their affairs in a businesslike manner.—E. W. JONES.

Edward H. Taken, building superintendent of Cook County Hospital, pulls out the rack of a Vulcan Gas roasting oven in the hospital's new central kitchen for the inspection of Miss Millie Kalsem, chief executive dietitian, and Warden Fred A. Hertwig. Equipment was installed by Duparquet, Inc.

1 modern GAS kitchen replaced 6 smaller ones at Cook County Hospital

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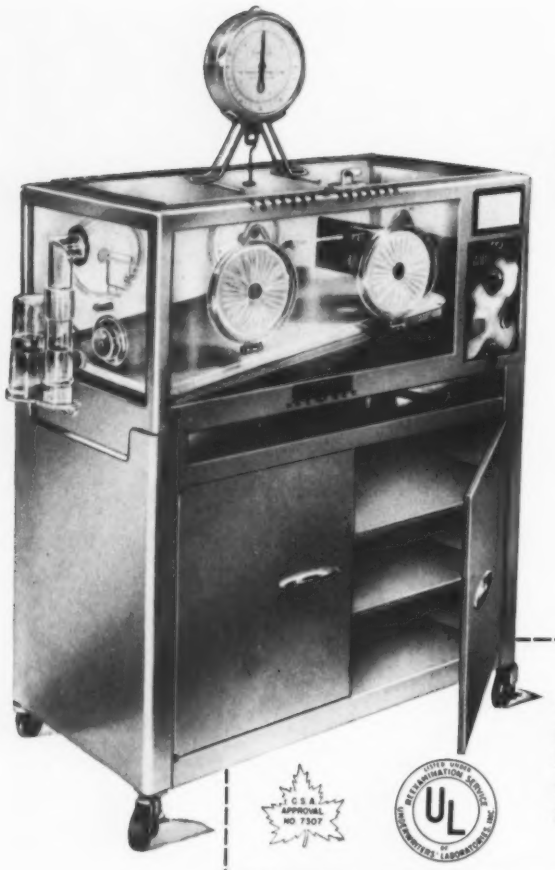

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HILL-BURTON EXPANDS

If local communities are willing to carry their share of the costs, the country will build about 15,000 new chronic disease and nursing home beds in the next three years. Also, present facilities for nonhospital outpatient care will be more than doubled.

The prospect grows out of passage by Congress and signing by the President of the Hill-Burton expansion law. The White House estimates the act will result in the construction of 2700 additional beds for chronic disease cases and 2200 for nursing homes, in addition to clinics and rehabilitation facilities for 12,000 more patients a year.

To get federal grants under the program, the local communities must raise part of the money themselves, the amount varying according to the state's per capita income as well as population. However, in no case need any state pay more than 50 per cent. The act authorizes an annual appropriation of $60,000,000. Each state may shift around funds as needed for clinics, nursing homes or chronic disease hospitals, but it will have to spend the amount earmarked for vocational rehabilitation centers for that purpose or return it to the federal treasury.

While the program in theory is limited to three years, if it is successful and well received it likely will be continued indefinitely. The original Hill-Burton program for grants to complete hospitals was supposed to expire in 1951 but it has been extended without difficulty.

This is by far the most important piece of health legislation to come out of the first Eisenhower Congress. Although it lacks the popular appeal of the defeated reinsurance program, its long-range impact on the health care of the American people will be significant. Furthermore, it is not "an experiment," as the reinsurance program was admitted by its sponsors to be. Into the new act went all the experience accumulated during the almost eight years of the Hill-Burton program.

A White House statement accompanying the announcement that Mr. Eisenhower had signed the Hill-Burton expansion bill said in part:

"Construction authorized by the new act will release general hospital beds for the acutely ill that are now occupied by patients with long-term illness. The need for more beds for chronic illness is intensified by the fact that although the population has doubled in the last 50 years, the number of people over 65 has risen fourfold, with the ratio continuing to rise. Further, the average number of days of hospitalization required by persons over 65 is twice that for persons under 65. Many of this older-age group can be cared for at minimum cost in nursing homes to be built under the new authorization.

"Construction of diagnostic and treatment centers will enable persons, particularly in rural areas, to receive periodic medical attention in well equipped facilities without entering a hospital. Such centers will serve the function of an outpatient department in an urban hospital. Finally, rehabilitation facilities will enable more disabled persons to return to active lives of work or self-care in the homes."

The new program went into operation in mid-July. Nothing can be done to stimulate nursing homes, clinics or rehabilitation centers until completion of surveys to set up statewide priorities similar to those under the original Hill-Burton system.

However, there is nothing to interfere with the immediate start of grants for chronic disease hospitals, provided the federal share can be scraped out of the regular appropriation or the few millions appropriated for the start of the new program. Under the Hill-Burton program, the need for chronic disease beds has been kept under continuous survey and priorities already are established. The latest estimate of the Division of Hospital Facilities, U.S. Public Health Service, is that 265,649 more chronic disease beds are needed.

If communities are ready to start on chronic disease hospitals, officials of the division advise them to move right ahead. The first step is to contact the particular state health authority. By the time applications are processed, federal money will be on hand for the grants.

NOTE: In addition to the willingness of the community to raise its share of the cost, there are two other restrictions: First, sponsors must be public or nonprofit; second, the center, home or hospital must be under medical supervision or connected to a hospital, except that dental clinics must be under dental supervision.

The new act is expected to result in the building not only of more rehabilitation centers, but of more comprehensive ones. Presently, they generally are limited to physical therapy. The new type would be a comprehensive approach to the problem, providing also psychological testing, welfare, vocational training, and sociological services.

H-B GETS $75,000,000

The $75,000,000 recommended by the President and approved by the Senate for Hill-Burton grants to complete hospitals encountered no difficulty in the conference committee, which could have dropped the figure to the $65,000,000 recommended by the House. This is in addition to $35,000,000 for the new program, and salaries and administrative expenses for both.

The Public Health Service fund for its hospitals and medical care was one of the few health programs to be reduced by Congress. It has $33,000,000 for the current fiscal year, or $100,000 less than it spent last year. Without exception, the various Institutes of Health received substantial increases over last year's appropriations. The contrasting figures are Cancer Institute, $20,000,000 last year, $21,700,000 this; Mental Health Institute, $12,400,000 and $14,000,000; the Heart Institute, $14,500,000 and $16,600,000; Institute of Arthritis and Metabolic Disease, $7,000,000 and $8,200,000; Institute of Microbiology, $5,900,000 and $6,000,000; Institute of Neurology and Blindness, $4,700,000 and $7,600,000.

REINSURANCE BURIED

The vote that buried the President's reinsurance program in the House was a confusing combination of lobbying and political pressures. In the face of the Administration's drive for enactment, only the American Medical Association (with some help from health insurance interests) was standing out in opposition to the plan. The labor groups, which had denounced reinsurance at the hearings, were not working actively against it in the House.

Once debate started, however, it was apparent that a large bloc of Democrats was moving over into the opposition column. Their real objective might have been to deny the Republicans an admittedly attractive campaign weapon, but in the debate the Democrats concentrated on pointing out the flaws in the bill. One of the most damning talks, a straight analysis of the bill, was delivered by Rep. John Dingell of Michigan, one of the sponsors of socialized medicine legislation in other Congresses.

Whatever the explanation, the vote was the sharpest and most direct rebuke yet to Mr. Eisenhower. His reaction was an angry attack against those who opposed the bill, and a pledge to work for its passage as long as he is in the White House.

KAISER-WOLVERTON BILL A CASUALTY

Another of the casualties of late July was the Kaiser-Wolverton bill for federal guarantee of loans to hospitals and other health facilities. It was introduced and pushed hard by Chairman Charles A. Wolverton of the House interstate and foreign commerce committee. Supporting it were many labor organizations and industrialist Henry Kaiser, who said the bill would be the salvation of comprehensive health plans such as those he started on the West Coast. According to Mr. Kaiser, one of the great problems in starting clinics and hospitals is that banks don't want to make long-term mortgages on a one-purpose structure. The federal guarantee would make the loan more inviting to private lenders.

At one point Mr. Wolverton had hoped to join this bill with the reinsurance bill, but gave up the idea when the Administration continued to pull for reinsurance but not to show much interest in mortgage guarantees. With defeat of the reinsurance bill, Mr. Kaiser abandoned efforts to get the other measure reported out.

RECORD HEALTH LEGISLATION

Aside from reinsurance, the Eisenhower Administration appeared to be setting quite a record for health legislation enacted as adjournment time arrived. In addition to Hill-Burton expansion, Congress had passed a bill to expand and improve the U.S.-state rehabilitation program, and had about completed work on legislation to revamp the public health grants and to revise the tax structure, including a liberalization of medical deductions. Passed also was a bill to transfer responsibility for Indians' health care from the Indian Bureau (in Interior Department) to U.S. Public Health Service (in Department of Health, Education and Welfare). The social security expansion bill, with a provision to protect pension rights of disabled persons, was assured of passage. Relatively minor legislation included an amendment to the doctor draft act to permit the military services to deal effectively with suspected subversives, and a new law forbidding the shipment of fireworks into a state if the state forbids their sale.

NOTES:

A new formula has been adopted to determine the needs for beds for tuberculosis patients under the Hill-Burton act. Previously, the rate was set at two and one-half times the annual tuberculosis death rate for the years 1940 to 1944. This has been changed to make it two and one-half times the average rate for the latest five-year period for which statistics are available.

By delaying applying for commissions, residents deferred for the last hospital year caused federal planners some trouble. It was expected that all of these men would be commissioned and ready for active duty in early July. Instead, a high percentage of them just waited for orders from Selective Service. Meanwhile, because processing takes so long, the services had to place calls for older men who already were commissioned, but whom the services did not want to induct because of their age.

With legislation for contributory life insurance for federal employes assured approval this session, the Administration is prepared to work next year for a contributory health insurance program. The federal government would pay part of the cost and the employe could apply this to any type hospital, surgical or medical care insurance he chose.

One bill highly favored by physicians, dentists and many other self-employed groups made no progress at all. It was the Jenkins-Keogh legislation to allow a taxpayer to defer payment of income tax on a percentage of his income, provided it was applied to a pension fund. Despite the lack of action, however, sponsors of the legislation say it is gaining in favor at the Treasury Department and in Congress. It will be up again next year.

Also left to dry on the vine—although desultory hearings were held—was a bill to set up a federal hospital board. The current investigation by the Hoover Commission is expected to result in a recommendation of this nature to cut federal expense and avoid duplication.

The Modern Hospital
AUGUST 1954

LOOKING AROUND

Hurt

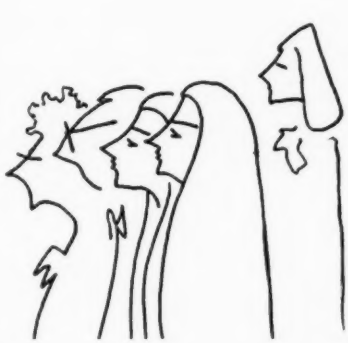
HOSPITAL in Memphis was sued for damages last month by a patient whose mustache was shaved off during an operation. Asked the court for $15,000 to compensate him for being "hurt and embarrassed" by the loss.

Whose Side?

MEETING in Chicago a few weeks ago, the American Nurses' Association voted to intensify its efforts to extend the economic security program for nurses and make the state nurses' associations collective bargaining agencies for their members. Specifically, an A.N.A. resolution urged "every state nurses' association to assume active leadership in the organization of local groups for the purpose of improving their employment conditions." The resolution also provided for development of a demonstration project "to give special assistance to state nurses' associations in developing their economic security programs," and for "long-range plans for training personnel to work on A.N.A. and state nurses' associations' economic security programs."

What is in store for hospitals as this drive gets under way is suggested in an A.N.A. "Fact Sheet" explaining the objectives of the economic security program. "Collective technics replace ineffective individualistic attempts," this says, answering a question about how the program works. "Nurses may assign bargaining rights to their state associations. Then when a group wishes assistance, the association acts as its bona-fide representative, using the specific action best suited to the particular work situation. Collective bargaining negotiations to obtain signed contracts, with effective grievance machinery, may be conducted for nurses in hospitals, industry, public health agencies, other institutions."

Efforts to extend collective bargaining for nurses now may be expected to bring up again a question that was raised, but not answered, a few years ago, when the economic security program was first introduced: Whose side is the nurse executive on? In most cases, the director of hospital nursing service and her principal assistants are members of the administrators section of the A.N.A. and thus plainly belong to the union. At the same time, these executives hire and fire nursing personnel, assign them to duty and supervise their work—thus obviously performing the functions of management.



What happens to the director of nurses and her assistants and, indeed, the supervisors and even head nurses who may also perform management functions when the union to which they belong is bargaining with the hospital they represent? It might appear that the unhappy nurse executive has painted herself into a corner and would have to (a) drop her association membership, (b) quit her job, or (c) bargain with herself. Actually, of course, most nurse executives will do nothing of the kind. Most of them will remain in their associations and in their jobs, unaware that there is any inconsistency in their position. This is because they have been in the habit of considering the A.N.A. as a professional society and are not accustomed to thinking of it as a union, or of themselves as union members, and also because they think of themselves as something separate and distinct from hospital management, rather than as part of it.

If the economic security program for nurses, including collective bar-

gaining by state nurses' associations, gets rolling in high gear in the months to come, as nursing leaders plainly intend that it shall, it will get increasingly harder for nurses and others to ignore the union aspects of A.N.A. membership. A.N.A. officials who sign the non-Communist affidavit of union officers required under the Taft-Hartley Act are conditioned to thinking of the nurse-hospital relationship in labor-management terms. Led by this concept, rank and file nurses will inevitably come around to the same view as time goes on.

If, however, hospital administrators can succeed in making nurse executives members of the management group, which they have never been in any widespread sense, the labor-management issue may not be joined as sharply in nursing as it has been in industry —a result that would gladden the hearts of many who regret the tendency of hospital practice to harden into industrial patterns. With her broad responsibilities for service and expenditures, mounting in most cases to 40 per cent or more of the total hospital budget, the director of nursing is not just another department head, as she is commonly regarded, but an executive with the stature of assistant administrator. When she is given the recognition and authority justified by her responsibilities, she may be expected to enlarge her view and join the management team. It can't happen too soon.

Mass Production

A RESOLUTION condemning so-called "closed panel" medical care plans as unethical was examined and, for the moment, set aside by the house of delegates of the American Medical Association, meeting at San Francisco last month. According to the resolution, such plans are unethical because their advertising or solicitation of subscribers directs patients to a restricted panel of physicians, thus benefiting those physicians and denying patients the right of free choice.

This is getting pretty far-fetched. If this concept of unethical practice is allowed to stand, it might also be considered unethical for any physician to practice in a town whose chamber of commerce advertises its attractions—since this would benefit the physicians in the town, as opposed to others. Actually, too, the physicians in the closed panel plans have about as much to do with the solicitation of patients by the plans as they do with chamber of commerce advertising.

If there is a case against any of the closed panel plans, this isn't it. A much better statement of what may be missing in closed panel practice was made not long ago in a letter written by Dr. Malcolm S. Watts, chairman of the advisory council of the San Francisco Medical Society. "No one who knows Mr. Henry Kaiser can doubt his sincere desire to provide a plan for the medical care of the average individual at a price he can pay," Dr. Watts wrote, referring to the Kaiser Foundation medical plans which have enrolled nearly half a million people on the West Coast. "But we submit that he, too, is trained and experienced in terms of mass production, and that the care he provides has some, and to us undesirable, characteristics of mass production care. Its relatively low cost can only bear this out.

"We take issue with this philosophy of mass production technics in medicine. We know that the best medical care must be individualized and tailored to meet the needs of each patient. We know from very long experience that this can best be accomplished by the particular interest of the individual physician in the individual patient. This is the essential element of our faith in the private practice of medicine."

Speaker

ANSWERING a question from the floor during a discussion on accreditation at the Middle Atlantic Hospital Assembly this spring, Dr. Anthony J. J. Rourke flashed his own rare combination of wit and wisdom. The question had to do with the number of times an administrator could call the doctors on delinquent records, and it reminded Dr. Rourke of the lady who visited a silver fox farm and asked the rancher, "How often do you skin your foxes?"

"Well, ma'am," the rancher replied, "if you do it more than once a year, it makes 'em awful nervous."

This reminded *us* of a suggestion we've been meaning to make: The American Hospital Association, we think, should have as one of its permanent officers a speaker of the house of delegates, who would be elected, and retained in office, solely on the basis of his ability to perform effectively as presiding officer of the house. A.H.A. presidents are chosen for many other qualifications; some of them are better than others at the difficult task of presiding over the deliberations of the house. But the A.H.A. is important enough, it seems to us, to demand its most adroit leadership at its official business sessions.

Break

EVERY administrator has had the experience, not once but many times, of wanting his secretary, or an assistant or department head, at a particular moment, only to find the missing member is out for coffee. Annoying as this is, it's a fact of life that business executives everywhere have to accept today; according to a recent survey, the coffee break is now a fixed custom of 35,000,000 Americans, and is still expanding.

As a matter of fact, hospitals have it a little better than most businesses, because they serve coffee on the premises, thus reducing the time and distance consumed by employes who are hell-bent for coffee. The cost of coffee time can easily become exorbitant when employes have to travel a block or more to a restaurant or canteen, then wait around for service.

Happily, there are benefits. A survey of management officials in more than 1000 companies a year or so ago indicated that 82 per cent believed the coffee break reduces worker fatigue, 75 per cent think it improves employe morale, and 62 per cent believe it increases worker productivity.

The experts say YES to the question:

Should Hospitals Buy Liability Insurance?

The cost of adequate liability insurance is an operating expense which cannot be safely avoided

RICHARD C. SLEEPER, C.P.C.U., and DWIGHT W. SLEEPER
Associate Consultant and Chief Consultant, Respectively
Insurance Buyers' Council, Harwich Port, Mass.

DISCUSSION with hospital administrators and attorneys in various parts of the country indicates that there is a difference of opinion with respect to the need for and the wisdom of purchasing insurance to protect a hospital against its legal liability for bodily injury suffered by patients and visitors. This difference of opinion is not strange, inasmuch as there is a wide variation between the opinions of the courts and of the legislatures in the various states. Some persons will grudgingly admit a need for the hospital to buy insurance protecting it from its liability for injury to *visitors*, but will argue that a hospital in a state where the courts or the legislature have granted full or partial immunity from liability for injury to patients should not buy malpractice insurance.

One insurance executive, who is also a trustee of a large hospital, with whom we had occasion to discuss this question stated that he was advised by a competent attorney that donors to a hospital could hold trustees personally liable for spending the donors' funds for liability insurance instead of for the benefits of patients.

In a series of three articles, we shall discuss the reasons for and against the purchase of liability insurance, give the readers a current picture of the status of immunity of charitable institutions at this time, and analyze the insurance protection which is available and the many problems surrounding its purchase.

The difficulty in discussing the question of the need for liability insurance lies in the fact that no single discussion will apply equally to privately owned hospitals operated for profit and the many types of voluntary and public hospitals which are not operated for profit. The discussion is further complicated by the wide diversity in the rulings of the courts of the various states relating to the liability of hospitals, whether private or public, and whether operated for profit or not.

Liability of Private Hospitals Operated for Profit. When a hospital, sanitarium or similar instruction is operated for the profit of the owners or other persons, the courts seem to hold that these institutions have the same legal liability to persons injured on their premises, or arising out of their operations, that any other commercial business activity would have. This type of institution can be held legally liable for any injury to patients or visitors arising out of accidents on or about its premises, growing out of its negligence or omission to maintain the premises safely, and for the negligent acts of its employes on the premises or elsewhere. Furthermore, inasmuch as it undertakes to provide extraordinary service in the care and treatment of the sick and wounded, it may be held legally liable for injury to patients arising out of a failure to provide, or negligence in rendering, the expected medical, surgical, nursing or other professional services.

It may be argued that private hospitals cannot be held liable for injury caused by negligence of a professional nature, on the grounds that physicians and interns are independent contractors and so are liable for their own acts. While this argument may be valid under some circumstances, many states hold that when a private hospital operated for profit contracts to perform medical or surgical duties beyond the scope of routine medical service it is liable if the physician or

This is the first of three articles dealing with hospital liability for malpractice or negligence resulting in injury or death of patients, and the hospital's need for insurance to cover this liability. The second article, which will appear next month, will discuss the differences between general liability insurance and malpractice or professional liability insurance.

If nurses realized that they are not always protected against damage suits, hospitals might have even more trouble than they do with nurse recruitment.

surgeon undertaking to render such duties is negligent in the performance thereof. If the hospital agrees and undertakes to perform such services, it is denied the right to escape liability by claiming that the person selected to do the work is an independent contractor.

Where injury results from the failure of the private hospital properly to maintain its property and to provide safe furnishings and professional equipment, it cannot expect to escape its legal liability for damages arising therefrom. Since injury to patients may be caused by error or mistake in rendering of a professional service or treatment, or the omission thereof, by nurses and other professional employes of the hospital, the private hospital operated for profit must expect to be held liable for damages resulting from injury occasioned by these acts or omissions.

While it is possible that the laws of some states are such that in a few cases the private hospitals operated for profit can escape from liability, and therefore have no need for insurance protecting them against liability, these circumstances will be so rare that a private hospital should decide not to purchase liability insurance for injury to persons only after careful investigation by its attorneys. It must be remembered also that even if the court should hold in any damage suit that no liability exists against the hospital, there will still be the expense of employing an attorney to prepare the case and to represent the hospital before the court.

Liability of Voluntary and Public Hospitals Not Operated for Profit. Much has been said during the last 10 years about the varying degrees of immunity from liability for injuries suffered by patients and visitors granted to the so-called charitable institutions. Because this is not intended to be a legal treatise, we shall not attempt to go into an explanation of the many arguments which have been advanced for or against this immunity, but will only refer to the trend away from immunity which has developed during this last decade.

During 1953 the state of Washington supreme court reversed previous rulings and held that the theory of charitable immunity based on public policy no longer exists, and decided that charitable, nonprofit hospitals should no longer be held immune from liability for injuries to paying patients caused by the negligence of employes. In this case, Pierce *vs.* Yakima Valley Memorial Hospital Association, the alleged negligence consisted of the act of a nurse in injecting a foreign substance into a patient's left arm, causing pain and permanent injury. In deciding this case, the court reviewed the findings of the various states, and concluded that in a case of this kind, 26 courts would grant immunity, 20 would deny immunity, and in four states and in one territory the results would be doubtful. According to this decision, eight states, Arkansas, Kansas, Kentucky, Maine, Maryland, Missouri, Oregon, and South Carolina, would still grant complete immunity. The court found further that Connecticut, Idaho, Indiana, Louisiana, Ohio, Massachusetts, Michigan, Nebraska, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Texas, Virginia, West Virginia, Wisconsin and Wyoming grant only partial immunity. Some grant immunity only with respect to charity patients; some grant immunity to some or all patients, but not to servants, visitors and strangers; some grant immunity with regard to negligence of employes but not negligence in the selection of employes and providing of equipment. In New York, the courts do not apply the immunity rule as such, but reach the same result in a case of this kind by holding that hospital nurses under the law are employes of the patient rather than of the hospital. In Rhode Island the immunity rule is established by statute, and in Maryland the immunity rule is apparently overcome by statute in cases where the institution carried liability insurance.

Immunity would be denied in Alabama, Alaska, Arizona, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Illinois, Iowa, Minnesota, Mississippi, New Hampshire, North Dakota, Oklahoma, Puerto Rico, Tennessee, Utah and Vermont. In Colorado, Georgia, Illinois and Tennessee, execution on a judgment can be had only against nontrust property, such as liability insurance. There are five doubtful jurisdictions, Hawaii, Montana, New Mexico and South Dakota, where no reported cases are found, and Nevada, where the one reported decision provides no reliable indication of what the courts would decide on a case such as the one cited.

The court stated that since 1943 three states and one jurisdiction, Arizona, Iowa, Mississippi and Puerto Rico, have abandoned the immunity rule and in this process have overruled earlier decisions. Four other states at the same time have rejected the immunity rule as a matter of first impression, and the opinion among scholars outside of the courts is almost universally in favor of liability.

The decision of the Washington supreme court increased to five the number of states which have reversed previous opinions. Since this decision, the supreme court of the state of Wisconsin in the case of Carlson *vs.* Marinette County (9 CCH Negligence 720) abandoned the immunity rule to hold that a hospital can act in the dual capacity of a proprietary and a charitable institution. In the free treatment of its own indigents, it is a charitable organization, but in the treatment of full-paying patients receiving relief from a condition which creates no public danger or problem, it actually acts in a proprietary capacity and in that capacity it is liable. Thus, in the last 10 years six states have abandoned the immunity rule. The Washington supreme court concluded that "there is today no factual justification for immunity in a case such as the one cited, and the principles of law, logic and intrinsic justice demand that the mantle of immunity be withdrawn."

It is interesting to note that in not a single case which has been tried before an appellate court during the

last decade has any court granted immunity where none had previously been allowed or extended any immunity which had already been limited.

The trend during these years toward abandoning the immunity rule has been so definite and unwavering that one must conclude it is only a matter of time before either the courts or the state legislatures in the remaining states, which do grant immunity, will be forced to follow the modern trend and hold charitable institutions liable for their acts of negligence or the negligent acts of their employes and agents.

The Wisconsin case referred to is noteworthy in that the defendant was a county hospital operated by the county board. As such, it was a public hospital and was called upon to serve as charity patients the indigents of the county, although it did accept full-paying patients. In this case the injured person was a paying patient and the hospital was held liable for her injuries, although presumably the court would have granted immunity had the injury occurred to a nonpaying patient.

INSURANCE PROTECTS FUNDS

If the laws of any particular state, or the rulings of the courts within that state, hold that a hospital within its borders may be sued and damages paid to injured persons, it must recognize the need for insurance to protect its funds against the cost of defending and paying claims against it for damages arising out of injury to persons. The cost of such claims can be so great that the financial stability of the hospital and the continuance of its service to the community can be endangered. Awards in excess of $100,000 for injury to one person are no longer unheard of. If one person can receive indemnity for his injury in this amount, to what extent may a hospital be held liable for the injury or death of a number of persons resulting from some catastrophe such as fire, explosion, food poisoning? Few hospitals have sufficient assets to pay such damages and continue to operate.

In those states which hold a charitable hospital fully liable for its negligence, including negligence of its employes and agents, when such negligence results in bodily injury, the answer to the question "Should a hospital buy liability insurance?" must be in the affirmative. Insurance should be purchased by all hospitals, public or private, that accept any paying patients and those hospitals which do *not* accept paying patients should consult a competent attorney regarding possible costs of legal defense and payment of claims before deciding not to insure.

Insurance can be purchased to cover the cost of investigating every claim, defending every suit, and paying the damages awarded by juries if the court holds the hospital liable, or of settling the claims out of court, all regardless of whether the alleged injury arises out of the ownership, maintenance or use of premises, elevators or motor vehicles, or out of negligence or omission in rendering professional services, sales of drugs or other products used or consumed away from the hospital or dispensary, defects in equipment supplied or furnished by the hospital, mental anguish arising out of autopsies, and so forth.

In the purchase of liability insurance the hospital management should be consistent. What justification is there for purchasing insurance which covers only the accidents suffered by visitors and patients arising out of negligence in safely maintaining the premises, or caused by negligence of *nonprofessional* employes, but refusing to admit the liability for, and to insure against, injury resulting from so-called "malpractice" of employes in rendering, or in failing to render, services of a professional nature?

In states whose courts or legislatures have granted only partial immunity, the hospitals must weigh carefully the need for liability insurance. It is impossible to foretell how bodily injury may be caused or who may be injured. A hospital cannot safely rely on the argument that it is not liable for professional malpractice on the grounds that doctors and interns are independent contractors, for the injury may be just as readily caused by the negligence of some nurse, nurse's aide, orderly or other employe of the hospital, or be caused by some defect in equipment or furniture. The opinion of the courts in a few states that a hospital is liable for injury to paying patients but not to charity patients, or vice versa, should not affect the decision to buy or not to buy insurance, for who can say whether it will be a paying patient or a charitable patient who will be injured.

In states which up to this time have held charitable institutions completely immune from suits for liability, the need for buying such insurance is less apparent. Many reasons have been advanced for and against the purchase of such insurance. The two arguments most often advanced are: (1) it is a waste of money to buy liability insurance when the courts of the state have held such institutions immune from liability; (2) if hospitals generally purchase liability insurance of any kind, this will be an invitation for suits to be instituted against the hospitals for any and every kind of accident, and will make the defense of these suits very difficult.

MORAL OBLIGATION TO THE PUBLIC

The answer to the first objection involves the moral obligation of the hospital to its community, and the assumption of the business risk by the directors of the hospital.

Should a hospital place itself in the position of saying to the community: "If our next door neighbor leaves a spot of ice on his sidewalk in the winter and you slip on this ice and injure yourself, you can collect damages for the injury which you have suffered; but we can ignore our icy sidewalks and if because of our negligence you fall and are injured, that's your tough luck, because we can't be sued"? Or should a hospital say to one of its patients: "If you are injured or sick and need surgery or medical care, come to us; but remember that

The fear that the purchase of liability insurance will invite damage suits is not borne out by the experience of hospitals that are now protected by insurance.

if one of our employes drops you off a wheel stretcher and gives you a brain concussion, or if our nurses incorrectly prepare you for surgery, or one of our staff cuts off the wrong leg, we shall be sorry, but you can't expect to obtain any damages for your injury, because we are a charitable institution"?

INDIVIDUAL HAS NO IMMUNITY

No hospital would actually make such statements, but, in effect, this is what the management is saying when it insists that it cannot be sued because it operates a charitable institution. The United States Court of Appeals for the District of Columbia once observed (Wash. Law Reporter, Vol. 70, No. 42) "that when an individual undertakes not simply an isolated act, but a habit or business of charity, without incorporating or casting it in the form of a trust, he does not acquire immunity. Possibly half of the medical service rendered today is charity practice. So also is a large share of legal service. Some physicians, and perhaps some lawyers, spend half or more of their long and useful careers ministering to the sick and the troubled without pay. Many more do it habitually, but less extensively. Yet, they do not have leave to be careless, notwithstanding that their kindness is habitual rather than casual or occasional. Only when an individual institutionalizes his charitable enterprises formally, as by incorporation or possibly by creating a trust, does he succeed in casting the whole burden of its negligent operation on those it injures."

The court observed that "it is a strange distinction between a charitable institution and a charitable individual, relieving the one and holding the other for a like service and like lapse in like circumstances. The hospital may maim or kill the charity patient by negligence without liability, yet the member of the medical staff, operating or attending without pay or thought of it, dares not lapse in a tired or hurried moment. The institution goes free. The physician pays. Yet they render a common service, which the hospital could not furnish without him."

A hospital which holds itself to be immune from liability imposes a burden upon its employes that we suspect few of these employes realize. Every person is liable for injury to others caused by his negligent act, regardless of whether he is acting in his capacity as an individual or as an employe in the service of his employer. If an employe of any commercial enterprise other than a charitable institution injures someone in the course of his employment, he may be sued by the injured party; but the employer is usually also sued, because it is recognized that the employe may have few assets of his own and probably carries no liability insurance, or such insurance with only a small limit of liability, whereas the employer's assets are probably much greater and it is expected that it will carry liability insurance with high limits to protect its assets. This gives the claimant some additional chance of being adequately compensated for his injuries, but it also provides a measure of protection for the employe.

A driver of an automobile belonging to his employer should know that if he injures some person or damages property through the careless operation of the automobile, the insurance company protecting his employer also has agreed to defend him if he is individually sued and to pay any damages awarded in a judgment against him. The insurance company writing general liability insurance for an employer does not agree to defend any individual employe or pay any damages arising out of claims against him, but the employe may have some feeling of safety in knowing that he will share the benefits from the competent legal defense which will be provided to his employer, and that in all probability the insurance carried by the employer will entirely or largely pay for the settlement of the claim.

An employe of a charitable institution that is immune from suits for liability and so does not buy insurance has none of this protection. If an employe driving an uninsured automobile belonging to the hospital is involved in an accident, he must depend entirely upon his own insurance protection, if any, and suffer the full weight of the consequences arising out of the accident. If a nurse injures a patient through some negligent act or omission, the employe of such a hospital must stand the full cost of defense of any suit brought against her, and her entire assets may be attached as a result of the judgment arising from the claim. Because of the very nature of her job, the nurse is exposed to many types of claims that would not occur in other types of employment, and yet she would have no direct or indirect insurance protection of any kind furnished by her employer. If the full import of this situation were realized by all nurses and similar persons, it seems probable that hospitals which claim immunity and carry no liability insurance would have even greater difficulty than they do in recruiting nurses.

Hospital trustees who decide against the purchase of liability insurance on the grounds that past decisions of the courts have held charitable institutions immune from liability may not be held personally liable for their failure to purchase insurance, but a heavy weight of responsibility will surely fall upon their shoulders if in a suit against their hospital the court finally decides to abandon the immunity rule within their state. Can a board of directors feel comfortable about subjecting its institution to this risk?

WILL INSURANCE INVITE SUITS?

It is understandable that a hospital which has enjoyed full immunity would be fearful that it will be inviting suits for liability resulting from every major and minor accident that occurs in or about the hospital suffered by patients or others; yet we wonder if such fear is borne out by the countrywide experience of all hospitals. Is there any evidence that hospitals in states where immunity still is granted are any more successful, or operate more economically, than those located in states where full liability is the rule? We serve hospitals which carry not only the usual general liability insurance but also professional liability (malpractice) insurance, and their record does not indicate any rash of claims. Their record is good and the number of claims is small.

The argument is analogous to the one in which one person holds that high limits of liability in insurance policies encourage claimants to make high demands for damages, while another person agrees that while this may be true, he cannot afford not to protect himself by insurance against these high claims.

Because of the irreversible trend toward making hospitals fully liable, and because of the hospital's moral obligation to its community, we can do no less than conclude that the hospital should accept the cost of adequate liability insurance covering its exposure to all types of claims as an operating expense which cannot be safely avoided.

A woman in her late 'Sixties is not too old to do an excellent job in the sewing room as Florence B. Seaboldt and her colleague Nora Hull (not shown) have successfully proved.

If personnel shortage is a problem

Don't Overlook Those Older Workers

DAVID BABNEW Jr.

Administrator, Northampton Accomack Memorial Hospital, Nassawadox, Va.

HOSPITAL administrators and personnel representatives realize that various types of labor turnover are unable to be avoided, and can be quite helpful.

Promotions, marriage and pregnancy are socially and economically quite sound reasons for hospital labor turnover, and they are instrumental in preventing the labor force from stagnating. Those of us interested in personnel, whether in industry, business or hospitals, know that a static group of employes does not exist. If no other factor brings about a change in the working force, time does.

However, in our hospitals, the need for replacements or additions depends to a large extent upon the success of the personnel department in reducing labor turnover. Even in those industries and business organizations that possess the best personnel policies and practices, a labor turnover of 5 per cent per year over the long run is not uncommon. Much higher rates of turnover are common in the hospital field, yet an adequate source of labor must be maintained.

When this article was written, Mr. Babnew was director of personnel and public relations at the Reading Hospital, Reading, Pa.

For many jobs within the Reading Hospital, we have found that the best source of supply is those persons already in our hospital family. Frequently our employes are promoted, and they in turn recommend competent persons who can fill the vacancy. By attempting to develop understudies for supervisory positions, we have found that one vacancy results in 10 promotions. When our purchasing clerk left, our storekeeper was elevated into that spot; one of our ambulance drivers was promoted to storekeeper; another employe with several years of service was given the job of ambulance driver.

Occasionally, when such a series of promotions occurs, it may be found unnecessary to employ a person to fill the last rank vacated. In many instances a reassignment or readjustment of duties will provide for the continued performance of those tasks that were previously done by the last promoted employe. When a vacancy occurs in the hospital and a chain of promotions creates a vacancy down at the maid or porter level, the opportunity is provided for drawing in any slack that might exist in the organization. We find that successful application of a promotion-from-within policy requires an accurate and complete knowledge of the employes within the hospital. Therefore, our department of personnel must keep adequate records. However, no organization can thrive and grow by feeding on itself alone. It is necessary in our hospital, just as in yours, to procure workers from the outside.

We have encouraged the present members of our hospital family to introduce their friends and relatives. Those employes whose work and standards are high generally attract to our hospital similar persons, yet you cannot neglect the thought that ill-will may be engendered when an employe recommends someone who is not hired or someone who is fired because of unsatisfactory work after he has been hired. Our personnel department requires that present employes be informed that their friends or relatives will be required to meet the standards established by our hospital when they make application for a position.

When we have job vacancies our department of personnel consults the applications of qualified persons on file in our office. We classify, file and keep current the application blanks of all potential workers. At the end of nine months we discard all appli-

cation blanks unless the applicant has reapplied or has stated his desire to have his blank kept current. We realize it would be rather shortsighted to rely upon the source of supply that is made available through applicants' solicitation.

By developing and maintaining adequate personnel records and folders, our personnel department is in a position to judge, with a considerable degree of effectiveness, the value and possible placement of former employes who, for some legitimate reason, were obliged to resign. Since we already know the capabilities as well as the shortcomings of these people, we believe this is an excellent source of recruitment.

Educational institutions serve as a worth-while source of potential workers, and our various department heads frequently appear on high school assembly and guidance programs. These younger applicants are usually inexperienced, but they possess the advantage of education, and training that the casual applicant lacks. Many of these recruits have made successful office workers, nurse's aides, and kitchen workers.

The Pennsylvania State Employment Service has also been helpful in referring innumerable applicants to us. We do not fail to screen these applicants. Some private employment agencies are more concerned with the mechanical sending of applicants for consideration than with the selection of job applicants to meet the employer's needs. These agencies are interested in the fees paid by job applicants. The Reading Hospital has been quite fortunate in having access to several accredited private agencies which strive to meet the needs and requirements of our institution.

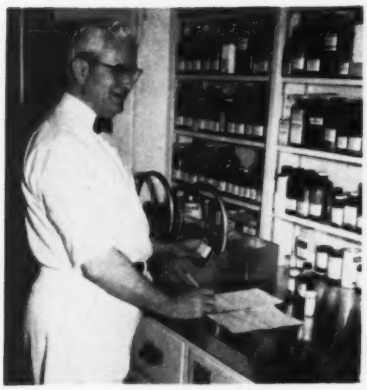
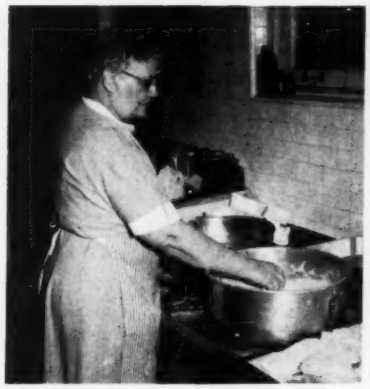
Generally speaking, advertising is another method of obtaining help, but our personnel department has found that this method is not very satisfactory. Although some worth-while applicants are obtained by this method, we find that advertising brings large numbers of floaters, malingerers, perverts and others who are unfit for hospital employment.

Louise Barto, employed in diet kitchen.

Left: At 81, Wilson H. Eisenbrown is still handy with a push broom. Right: Retired Minister Victor J. Hammond works in the central supply room.

Has your hospital attempted to use older workers? From an employer's point of view, when is a worker considered old or aged? Persons currently employed would have the term "aged" applied to them regardless of their specific calendar age whenever they were unable satisfactorily to perform their usual duties or whenever they are unavailable for transfer to new duties because of the slackening of former tasks arising from technological changes or any other cause, the reason for such inability being directly ascribable to calendar years. Frequently, when quantitative data are presented, the term "older worker" includes all those persons 45 or over. But, as you know, this grouping is little more than a statistical convention. Considered from this point of view, some persons are old at 40 and others are going strong at 70.

No one age can be used to classify persons individually as to being young or old from the angle of work. Individual differences, the job, the industry, or the locality in which people live are the controlling factors and not calendar years. Certain workers in retail sales may encounter employment obstacles at 35 when another worker over 55 may have no difficulty in finding and holding a position. In Berks County some workers in the textile industries may be "old" at 40, and a pattern maker can be quite satisfactory at 60. Personnel directors must consider the kind and degree of skill involved, the job field, the status of the prevailing labor market, and the personal qualifications of the


Left to right: Carl W. Endler, pharmacy; Catherine Behney, nutrition department, and Charles William Smith, doorman.

individual job seeker, before the worker is unrealistically placed in the category of "aged worker" because he is over 45.

Dr. Ross A. McFarland of Harvard University School of Public Health pointed out at the world meeting of the Aero Medical Association last year that there are more than 1000 civilian pilots in this country past the age of 60. He indicated that a study of 60 civilian air crashes revealed that aging had nothing to do with the crackups.

These and other findings about the increasing number of people who accumulate many birthdays but fail to grow old brought a proposal from a Los Angeles psychiatrist that a method for determining a person's functional age might be useful to society.

Generally, for statistical purposes and reports, workers are classified as "aged" when they have reached the middle 40's or the maximum age of 50. Workers in this age range may have little or no difficulty if they lose their jobs and seek new ones.

Personnel workers will agree that there are two major problems involving the older worker: (1) the problem of the personnel director to obtain suitable work for those members of his organization who have grown old on the job and who are unable efficiently to perform their regular duties, and (2) the problem of the aged worker who is unemployed and encounters opposition to reemployment because of his age. These problems have sociological and economic implications.

Many people believe that full employment provides the solution to unemployment, especially for aged workers. However, this is somewhat of a generality. Under such conditions the size of the problem diminishes; yet, the aged workers, as compared to other workers, face greater difficulty in getting new jobs.

In the past, employers had various reasons for establishing age limits above which they refused to hire new employes. Consider some of the following:

1. Internal organization policy was promotion from within.
2. Inflexibility of aged workers.
3. Lack of adjustability.
4. Higher mortality rate.
5. More liable to accidents.
6. Establishment of the retirement age at 65 years.
7. Additional costs of pension plan where these are in use.

However, during the past few years great strides have been made in the attitudes, policies and practices of employers concerning the hiring and retaining of older workers. Business and industry are thinking and acting more constructively; hospitals have done the same, and wisely should continue along in the same trend.

From the National Conference on Aging sponsored by the Federal Security Agency in Washington in 1950, from conferences sponsored by groups authorized by state gatherings, and from the recommendations of the National Conference on Retirement, employers have begun to reflect a change in attitude toward the hiring of the older worker. They realize these older workers are a source of worth-while personnel when they are carefully selected and counseled.

At the Reading Hospital we have complete cooperation with the local public and private employment agencies. After careful counseling and screening, these older workers are sent to us for our consideration.

In order to benefit from this frequently forgotten source of personnel, we have willingly and advantageously added to our hospital family those older workers who could satisfactorily comply with our employment policies. Occasionally we find that older workers require more counseling than some of the younger workers; however, in many instances the older employe with wider experience is more flexible than the younger worker, and can be used for training purposes.

At the Reading Hospital we are convinced of the qualifications possessed by older workers and of the desirability of offering them equal consideration for the various job openings. We can mention the case of Carl W. Endler, age 55, who has been performing a very satisfactory job for us as a pharmacist. Then there is a retired minister, Victor J. Hammond, age 70, who has been supplementing his income by working in our central sterile supply room. Wilson H. Eisenbrown, age 81, serves as one of our porters as well as the owner of a landscaping service. Two of our seamstresses, Florence B. Seaboldt, age 67, and Nora Hull, age 68, are gainfully employed, and two other of the many so-called older workers performing competent jobs in our nutrition department are Louise Barto, age 66, and Catherine Behney, age 70. For the last 29 years genial Charles William Smith, age 68, has been serving as a doorman and messenger in our hospital.

When the "older workers" made up only a small proportion of the population this waste of human effort was negligible. However, we in the hospital field must not overlook this wealth of human resources in our endless task of obtaining personnel.

Small Hospital Forum

A small hospital administrator reports on

The Impact of Accreditation

T. B. STEVENSON
Superintendent
Colleton County Hospital, Walterboro, S.C.

ONE of the best methods I can use in pointing up the need for accreditation and the benefits to be derived from it is to turn the spotlight on one hospital with which I am familiar and, after giving you some of the essential facts regarding it, to tell you of its efforts to achieve accreditation up to the present time. The hospital is the one with which I am connected, the Colleton County Hospital, Walterboro, S.C..

Colleton County Hospital is located in the coastal section of the state in a county seat town that has a population of 7000. The county has approximately 30,000 residents, 48 per cent white and 52 per cent Negro. Its principal industries are agriculture and lumbering. It has several small manufacturing plants and is considered something of a tourist town, as it is located on two main North-South highways. Most of the patients come from the town and county but the hospital does have quite a few patients from all the adjoining counties.

The first hospital established in Walterboro was a 20 bed private hospital known as the Charles EsDorn Hospital, established in 1915. It had grown to 45 beds by 1945 when its operation was assumed by the county under the direction of a county board of trustees. In order to obtain larger facilities, in 1947 the hospital was moved to a near-by air base hospital plant about 3 miles from town where it operated until 1952, when it moved into a new 100 bed unit built under the Hill-Burton Act.

Our hospital is ideally located in the residential section of the town away from disturbing noises and on a beautiful site. From an average census of 40 patients in 1951 at the air base hospital, the census had risen to 80 patients in the new hospital in 1953. The present building is a modern, fireproof building of 100 beds and 20 bassinets, fully equipped with the latest types of furniture and equipment. A 15 bed nurses' home adjoins the hospital.

RURAL AREAS REPRESENTED

The governing board has 12 members appointed by the governor upon the recommendation of the legislative delegation from the county. Six board members are from Walterboro and the other six from representative rural communities in the county. Originally appointed in 1943 to construct a hospital building, the 12 board members have served continuously since. They serve without remuneration and have demonstrated that they are deeply interested in the health of the people and the welfare of the institution.

The medical staff is composed of 12 physicians, all of whom live in the county, 11 of them in Walterboro. All are general practitioners, although several have done extra study and work in some branch of medicine. Three members of the courtesy staff reside in an adjoining county, and an associate member comes each Tuesday from Charleston. The medical staff has always held monthly meetings with the program being devoted to a report of the work of the hospital for the past month and a discussion of the deaths and serious and unusual cases. The minutes of the staff meetings were rather carelessly kept in the the past. By-laws were adopted in 1945.

The hospital has about 120 employes in the various departments, with a competent, experienced, if not always formally trained, person in charge. The nursing department consists of a superintendent of nurses, afternoon and night supervisors, head floor nurses, and 20 registered nurses. There are 15 registered practical nurses and 20 other practical nurses, some of whom have had some nursing school training but most of whom we have trained on the job. The operating room is fully staffed with a supervisor and three other nurses. We have a registered nurse anesthetist. The nurses meet from time to time with the superintendent of nurses for direction, information and discussion of problems.

This, then, was the hospital situation at the end of 1952. We had a well equipped physical plant, a community willing and anxious to support the hospital, an energetic governing board, a medical staff which had the confidence of the people, an adequate staff of capable personnel, and an administrator who was anxious to have his hospital rated with the best. There had been no previous attempts to obtain accreditation of the hospital by the American College of Surgeons.

Soon after the formation of the

Condensed from a paper presented at the Carolinas-Virginias Hospital Conference, April 1954.

Joint Commission on Accreditation of Hospitals, I wrote commission headquarters that we were interested in accreditation and asked for full information. In reply, I was advised that a representative of the commission would visit our hospital within the next six months to make a survey and was told where I could get a copy of the standards of accreditation. These I studied carefully. The more I examined the standards the more I realized that there was quite an undertaking ahead of us. It did not take me long to realize that we were not ready for a full survey but rather for a visit from a representative of the commission to go over the program with us and to point out the areas we should work on in order to be ready for an inspection.

The realization also came to me that I had a job cut out for me in educating the governing board, the medical staff, and the personnel of the hospital about the accreditation program and in convincing these groups that we really needed to work toward accreditation. With this in mind, the matter was brought to the attention of the governing board at its January 1953 meeting. The nature of the accreditation program, its aims and objectives were fully explained and discussed. It was pointed out that in response to my invitation a representative of the commission would soon visit the hospital to make an inspection and that a full report of his visit would be made to the board. The board expressed itself as being in full accord with the idea of accreditation and promised its full cooperation.

Next, the medical staff was approached on this matter. After a full discussion of the purposes of the accreditation program and just how well the hospital would measure up to the standards, the medical staff voted unanimously to work toward accreditation.

On March 11 came the visit of the staff representative. We were given fairly short notice of his visit and it was unfortunate that both the chief and secretary of the medical staff were out of town on that afternoon. A form that had been sent us to furnish essential statistics had been prepared.

The representative was shown over the hospital plant and his questions about the nursing, x-ray, laboratory, dietary and housekeeping departments were answered. We spent an interesting two hours discussing the medical staff, its organization, by-laws, type of meetings, general operation, methods of keeping the patient records. Following this the patients' records in the medical record room were inspected. What the staff representative found in this examination confirmed our original belief about our not being ready for an official survey. We then spent some time discussing the accreditation program as a whole. He promised to give us a report of his visit and to point out the principal areas that we needed to work on.

COMMISSION VISIT HELPFUL

Let me pause here to say that this visit of the staff representative was most helpful and instructive to me. It gave me an opportunity to ask questions and to get authoritative opinions on many phases of hospital operation. The commission representative was courteous and sympathetic. He advised me how to proceed from that point, and his encouragement and enthusiasm for the accreditation program strengthened my resolution not to stop until the hospital had become fully accredited.

At the next meeting of the medical staff, I made a full report on the representative's visit. I told of his inspection of the hospital, his questions about the medical staff and its operation, and his opinion of the way in which our medical records were kept. I informed the staff that, in the opinion of the representative, our greatest weakness seemed to be in medical staff organization and medical records. These two were then fully discussed, and it was decided that the first step to be taken by the staff toward accreditation was to formulate and have adopted by the staff and the governing board a new set of by-laws, rules and regulations for the medical staff.

Pursuant to this resolution, a committee was appointed to draw up by-laws in conformity with those suggested for small hospitals by the American College of Surgeons and to include in these by-laws such necessary rules and regulations as would require that proper medical records be kept by the medical staff. It was further suggested that the committee incorporate in these by-laws such penalties as it deemed advisable for failure on the part of any member of the staff to abide by these rules and regulations.

This committee got right down to work by getting a sample set of by-laws from the American College of Surgeons and also copies of staff by-laws from other hospitals in the state. It spent quite some time in preparing these by-laws. When completed, they were presented, discussed, amended and adopted by the medical staff at its next meeting. Meanwhile, the chief of staff had informed the hospital board that, at its next meeting, the staff would like to appear before the board and present these new by-laws. At the June meeting of the hospital board, a group from the staff presented the by-laws, pointing out that these constituted the first step toward obtaining accreditation for the hospital and that the old set of by-laws was outmoded. No action was taken by the governing board on the adoption of these by-laws at this meeting but the staff was told that the board would study them and probably would need additional conferences with the staff before final approval.

Following this the governing board discussed briefly these new by-laws. There were two points on which the board seemed to have doubt. These had to do with the restrictions placed on the privilege of doing major surgery and the question of who should have final authority in the appointment of staff members. In subsequent meetings these two points were discussed fully, and certain compromises and changes were made in the original draft of the by-laws. Finally, after much work on the part of the staff, the new by-laws were adopted at the December 1953 meeting. Soon afterward, they were printed in a neat and attractive booklet. The staff then felt that it could go ahead with its part of the accreditation program, having obtained the approval and backing of the governing board through the new by-laws, rules and regulations.

In the meantime, a report on the

There are many obstacles in the path of a small hospital seeking accreditation but they can be overcome—and the benefits are worth the effort

representative's visit to the hospital was received from the Joint Commission. I feel that if I enumerate some of these deficiencies it will be helpful to those of you who are now working toward accreditation. I shall list them according to the various departments of the hospital.

MEDICAL STAFF

1. Adoption of by-laws, rules and regulations signed by all members of the medical staff.

2. Adoption of regulations for staff membership which contain the proposal of financial relation to the professional care of the patient.

3. Appointment of executive, credentials, records and tissue committees of the staff.

4. Meetings of the staff to be held monthly with an accurate record of attendance averaging at least 75 per cent of the active staff.

5. Minutes of the medical staff meetings to be concisely recorded and to reveal a thorough review and analysis of the work done in the hospital.

6. Appointment of a head of the surgery department and a surgical staff committee. Limitation of surgical privileges in writing. More adequate control of surgical work done in the hospital. Operating surgeon to record and sign preoperative diagnosis prior to surgery. All infections of clean surgery cases to be routinely reported, recorded, listed and investigated.

7. Review and analysis of selected obstetrical cases at monthly staff meeting.

8. Evidence that all the medical staff committees are actively at work.

MEDICAL RECORDS DEPARTMENT

1. Need for services of a consultant registered or equivalently qualified medical record librarian to organize an acceptable records department.

2. Medical records to be written by the attending physician with complete record—complaint, present illness, past and family histories, physical examinations, consultations, diagnosis, medical and surgical treatment, progress notes, and condition on discharge.

3. Active control of the filing of completed records by the records committee of the medical staff. Completed records to be signed by the responsible attending physician. Cross-index in relation to disease and operation to be kept up to date. Time for filing records not to exceed one month's discharges.

4. Autopsy rate averaging 20 per cent of institutional deaths.

5. X-ray findings cross-indexed. Routine x-ray of chest for patients on admission suggested.

6. Complete recording of histories and physical examinations. Consultations to be recorded and signed by consultant in all cases in which diagnosis is obscure.

Sufficient recorded evidence of preoperative study in surgical records. Recording of postoperative cases. Cesarean sections of 11 per cent to be carefully investigated. Record of consultations, to be signed by consultant in all major gynecologic and obstetrical surgery and in therapeutic abortion.

NURSING DEPARTMENT

Regular conferences of nursing staff to be held at least monthly. Nursing service for obstetrical patients to be completely separate as far as possible. Newborn nursery to be under supervision of qualified pediatrician.

OTHER SUGGESTIONS

Routine laboratory examination on all patients upon admission.

Postanesthesia follow-up to be recorded.

Postanesthetic recovery room recommended.

Active pharmacy committee of medical staff to be appointed and a hospital formulary to be adopted and kept up to date.

This is by no means a complete list of recommendations from the commission on which we must work for improvement. The entire list was read to the medical staff at its July meeting and discussion ensued as to which of these areas we could begin to work on, pending approval of the by-laws by the governing board. Certain of these were selected and work was started on them. For instance, soon after this we put into operation the postoperative recovery room. At each of the staff meetings that followed, there was always some reference to the accreditation program and just what progress was being made.

After approval and adoption of the new by-laws, rules and regulations in December 1953, the staff met and formally organized, appointed committees, and discussed further ways and means of strengthening its work. In the meantime, the staff and the hospital board had been provided with reprints of the article "A Hospital Becomes Accredited" which appeared in the July 1953 issue of *Hospitals*.

In January 1954, the medical staff invited Dr. Julian P. Price of Florence, S.C., a member of the board of commissioners of the Joint Commission, to come to Walterboro and discuss the accreditation program. Members of the governing board were invited guests of the staff at this dinner meeting. Dr. Price gave an excellent discussion of the accreditation program as it would affect our hospital, stressing the part the medical staff should have in it. The stimulating discussion period following his talk indicated the intense interest of the staff and board members in the program. The educational value of a meeting such as this cannot be overestimated, and its influence is indicated by the fact that at each of our board meetings since some mention has been made of the accreditation program and the progress we are making.

From this description of what has happened since January 1953, I believe you will agree that we have made some progress. We still have quite a bit to do, but I think we are headed in the right direction and, if we continue along these lines, we shall be ready for a real survey in 1955. I think it is not too soon to attempt to evaluate what has been and will be done. These are some of the beneficial effects to our hospital, as I can see them now, of our efforts toward accreditation.

First, let's look at the medical staff. In its work on the new by-laws, rules and regulations, it has exhibited a spirit of willingness to work together and a unity of purpose. It has accepted the challenge to do its part in the program of improvement designed to ensure better care to patients. It realizes its responsibility in the matter of keeping better patient records. Histories and physicals are being done now although some of them are rather brief. The programs of the meetings have also improved in that more time is devoted to discussion of selected cases in the hospital at the time. The minutes of the meetings are full and well kept. The records and tissue committees meet regularly. Several surgeons have been advised that from the records available it appears that certain of their operations were not justified. Attendance at staff meetings is much better. A committee is at work now preparing a list of medical books and periodicals that should be included in our medical library.

Next, the medical records. This has been one of our weakest points. In most cases, the records have been incomplete, too brief, with not enough information to sustain the diagnosis and justify the treatment. A notable improvement has been made recently. Histories and physicals are being written; admitting diagnosis and complaint are usually entered on admission or soon thereafter; operative records are completed immediately after surgery. An anethesia and post-recovery record are kept, and all charts are completed by the attending physician much sooner after the patient's discharge than before. There is still much to be done on medical records, but I feel that with the start we have made that it can and will be done.

Among other beneficial effects can be noted an improvement in the nursing service, with efforts being made through regular conference periods to raise the standards of nursing care; and an improvement in the dietary department, including the preparation and printing of a diet manual listing all regular and special diets. In the laboratory routine work is being done on all patients who are in for more than 24 hours. The maintenance department is working on a disaster manual and a provision for fire drills. The housekeeping department seems to be taking greater pride in keeping the hospital spotless.

In attempting to raise their standards to meet accreditation, small hospitals will face several serious obstacles as shown by our experience. These are being mentioned with the hope that some solution to them may be offered. First of all, I should like to mention the scarcity of trained personnel to head up the various departments of the hospital. Adequately trained qualified record librarians, dietitians, laboratory technicians and nursing supervisors are especially needed. We have difficulty in getting obstetrical nurses. We are doing as much on-the-job training now as we can, but we need trained leaders for the various departments of the hospital. Full credit in these departments of the hospital cannot be earned unless the department is headed by a fully qualified person. If we cannot get such persons, what can we do?

Some small hospitals will find it difficult to earn credits because of the following: segregation of patients by services, indifference of trustees, noncooperative medical staff, lack of administrative leadership, obtaining autopsy consents, lack of qualified laboratory technicians and radiologists, shortage of nurses, high cesarean section rate, and failure to get consultations. Most of these problems must be solved before accreditation is given.

In my opinion, the key person in the hospital working toward accreditation is the administrator. First of all, he must be sold on the idea himself. He must demonstrate the leadership necessary to get the cooperation of the governing board, the medical staff, nurses and other personnel. He must be untiring in his efforts to improve every department of his hospital in order that the service rendered to the patients will be just as good as it is possible for it to be. His responsibility is great and cannot be shifted entirely to others if success is to be achieved.

Why Surgeons Support Accreditation

ORWOOD J. CAMPBELL, M.D.
Minneapolis

THE field of surgery, while no more important to mankind than are other medical fields, constitutes the greatest area of concern today as far as improving standards is concerned. This is true because surgery is easily subject to abuses, the most glaring and inexcusable being incompetently performed surgery, unnecessary surgery, fee-splitting, and ghost surgery.

Surgeons, like other representatives of the medical field, insist on independence of thought and action. Since surgery is not an exact science but an exacting profession, a certain degree of difference of opinion toward disease and preference for therapy is reasonable and desirable. No set of standards imposed either nationally or at the staff level should curtail this freedom of thought and action. It is only when a surgeon runs far afield at an unsupported tangent to established practices that his privilege to do so should be challenged by his staff confreres.

I mention this fact not as a criticism of hospital standards as presently established (these are not restrictive) but merely to show that, in supporting an increasingly exacting table of standards, the surgeon is overcoming his instinctive objections and is conforming for his own and the general good.

Why are we supporting a program that brings the hospital and the hospital board so strongly into the picture? Why is not the policing of the quality of medical care strictly and exclusively the province of medicine?

The answer probably lies in the fact that organized medicine has found it difficult, if not impossible, to know the level of competency of its membership or to regulate the quality of medical care.

The only control exercised by organized medicine over its membership is maintained through the threat of censure and/or expulsion. Court verdicts have made it so difficult to expel a member on any grounds short of gross incompetence or misbehavior that threat of expulsion ceases to be an effective means of policing the quality of medical service.

The most effective place in which medicine can police itself is at the

From a paper presented before the Upper Midwest Hospital Association, May 1954.

hospital staff level. There are two basic reasons why this is so. First, the practices of any staff member are known to his confreres, or are easily ascertainable, and, second, the courts have declared without any qualifications that the hospital board has absolute control over hospital and staff and may expel any staff member at its own discretion.

This, then, is why we as surgeons need you as hospital administrators as partners in our constant drive for improved surgical care and why we are willing to submit our record to review and even censure by our associates even though instinctively the idea may be repugnant.

I shall not use time in discussing the physical equipment of the operating room or the operating room nursing staff except to state that no hospital has a right to serve a community unless it does supply equipment and nursing personnel to enable the surgical staff to utilize its talents to their full extent. Minimum standards of excellence in this respect have been laid down by the American College of Surgeons.

The quality of surgical care in a given hospital is measured first by the competency of the surgeon. Competency in the operating room can best be assured by the selection of those granted operating room priviliges.

Who, then, shall operate?

CAN WAIVE "BOARD" RECOGNITION

The greatest assurance of competency can be obtained by granting full operating privileges only to those who are diplomates of the American Board of Surgery and/or fellows of the American College of Surgeons. Eventually such prerequisites for full surgical privileges will be required. At present, however, it must be recognized that there are many extremely competent surgeons, who, regardless of how they acquired competency, deserve recognition and full privileges. This recognition is afforded by action of the surgical staff which can recommend waiving the requirement of "board" or "college" recognition.

I wish to emphasize that this third category constitutes those whose competency is *now* established. It should not be held open as an inducement or loophole whereby a formal and adequate training may be circumvented. To leave such a loophole would be a decided blow to the efforts of all schools and societies that are seeking to train better surgeons and would constitute a disservice to the public.

The foregoing objectives must be considered as ideal and they presuppose the presence on the staff of a sufficient number of well trained surgeons to carry the load of that hospital.

Obviously, in smaller communities hospital staffs may not command such talent and the decision as to who shall operate and what type of surgery shall be done in small hospitals becomes a complicated and difficult problem. It involves such intangibles as the philosophy of the men practicing in the community, precedence, and the attitude of the hospital board, usually composed of laymen. In such a limited discussion, it is sufficient to point out that the possession of a license and the legal right to do surgery does not carry with it the moral right, unless they are accompanied by competence.

Fortunately, most small hospitals handle their surgical obligations well by recognition of the limitations of their staff, and either the importation of competent surgeons or referral of their cases to hospitals with fully trained surgeons.

ADMINISTRATORS MUST COOPERATE

May I say that as hospital administrators I believe you have an obligation under this new medical-hospital teamwork to interest yourselves in the competence of your surgeons and if you are unhappy about your situation to call it to the attention of your hospital board. This is not to invite a one-man crusade in your community but rather to point out that standards are established and that the accreditation committee, the American Medical Association, and the American College of Surgeons can give you help and at least let you know how you compare with similar hospitals in similar communities.

One last remark about hospital boards. Our whole effort to elevate the standard of surgical practices depends upon the degree of cooperation that we receive from the board and the board's willingness to back up the recommendations of the staff. Predominantly, hospital boards are made up of the finest, most public spirited and unselfish individuals to be found in a community. Were this not so, I cannot see why they should accept the sacrifice that their job entails. Occasionally, however, boards may not understand the over-all problem or may subjugate it to the individual problems of their hospital.

Recently an able surgeon confessed to me his discouragement at his and other staff men's efforts to limit the surgery of a very few men who were spoiling the record of an otherwise competent staff. When the board was approached, the surgeon was turned aside by the admonition, "Let them alone—they are doing all right."

Asked for my advice, I suggested that a campaign of education of the board was indicated and further suggested that two or three of the more receptive members of the board go with the surgeon to Chicago to visit the headquarters of the American Medical Association and the American College of Surgeons. What degree of success he has had, I have not yet heard.

POLICING THE STAFF

Moving on from a consideration of competency, let us next consider the problem of policing the surgical staff.

Unfortunately, there is not an absolute correlation between competence and intellectual honesty. A few bad actors are responsible for tissue committees. The establishment and activation of a tissue committee seems to be a necessary evil. There is no way to determine which hospital requires policing and which can be trusted, hence, the requirement that all hospitals must have a tissue committee as part of their requirement for accreditation.

A tissue committee can abuse or can pervert its function; it can dodge its obligations and fail of its purpose. On the other hand, even as it serves its police function in preventing unnecessary surgery, it can be a useful mirror for the surgical staff to view its own accomplishments and learn its own shortcomings in order to chart its own progress.

Personally, I favor a system in which the surgical staff as a whole acts as a tissue committee, taking turns at the routine work, such as correlations between diagnosis and pathology, and reporting to the surgical staff as a whole. Such a system has the virtue of bringing problems out into the open. Such a system can be used for the betterment of surgical practice in the hospital and serves as more than a mere board of censure.

Recently I was called as a consultant to see a young girl with her third attack of an acute abdominal disorder within the preceding three months. On each previous occasion the patient was hospitalized, her family was panicky,

(*Continued on Page* 134)

A.M.A. Abandons Registry of Hospitals

Delegates at San Francisco suggest registration and compilation of hospital data be handled by Joint Commission on Hospital Accreditation

THE American Medical Association will drop its hospital registration program and has requested that the Joint Commission on Accreditation of Hospitals take over the compilation of hospital data and registration of hospitals, in addition to its accreditation activities. This action was taken by the house of delegates, on recommendation of the board of trustees, at the A.M.A.'s annual meeting at San Francisco last month.

COUNCIL'S RECOMMENDATION

"The primary function of the Council on Medical Education and Hospitals is the improvement of educational standards at the various levels of medical education," the resolution approved by the delegates stated. "Inasmuch as the registration of hospitals does not directly involve programs of medical education and the Joint Commission on Accreditation of Hospitals is concerned with hospital standards apart from medical education and is in a position to carry out the registration of hospitals more effectively than is the council, it is recommended that: (1) the registration of hospitals by the council be discontinued; (2) the Joint Commission on Accreditation of Hospitals be requested to undertake registration of hospitals in addition to its present accreditation activities; (3) the council continue its statistical studies of matters relating to hospitals at least until such time as details of transfer be worked out; and (4) the 'Essentials of a Registered Hospital' be declared no longer in effect."

The registration of hospitals has been carried on by the A.M.A. since 1928. If the Joint Commission takes over the task, publication of an annual hospital number by the *Journal of the A.M.A.* will continue, with merely a change in the source of information, it is expected. Otherwise, this publication of hospital data will cease. The 1953 report by Dr. F. H. Arestad and Mary A. McGovern was published in the A.M.A. *Journal* for May 15, 1954. It covered 6840 hospitals, approximately half of which are approved by the Joint Commission.

Dr. Edward L. Turner, secretary of the A.M.A. Council on Medical Education and Hospitals, reportedly recommended the action on the basis that a simple listing of hospitals was not closely related to medical education or the approval of intern and resident training programs, the primary interests of the council. Commenting on the action, Dr. Turner described it as a part of the trend toward joint activities on the part of the A.M.A., the American Hospital Association, the American College of Surgeons and other organizations.

Also referred to the Joint Commission was an A.M.A. resolution recommending that the Council on Medical Education and Hospitals set up a separate system of standardization for smaller hospitals, "In keeping with their general size, personnel and facilities." In discussion of this resolution before the Reference Committee on Medical Education and Hospitals, it was pointed out that the Joint Commission already had a special committee on problems of small hospitals. The Reference Committee concluded that the Joint Commission, rather than the Council, was the proper agency to consider all matters concerned with hospital standardization, and the delegates concurred.

INTERN REPORT APPROVED

Continuation of the Intern Matching Plan was foreseen in approval by the house of delegates of the progress report of a special committee on internships which considered all aspects of the intern problem and recommended continuation of the matching plan as the best available solution at present.

In a lengthy report, Dr. George S. Klump, chairman of the internship committee, said that group would continue its studies, hoping to submit a final report to the house of delegates next December. "In considering the many facets of the general problem, the committee has endeavored to consider each solution suggested within the framework of policies previously enunciated by this house," Dr. Klump stated. "Among these are the principles of free choice for all persons or corporate bodies involved, voluntary, methods, and operation of the American competitive system."

Hospitals presently approved for internship have 20 per cent of hospital beds and account for 43 per cent of total annual admissions, the report indicated. The committee found another 800 to 900 hospitals which meet minimum requirements regarding number of beds and admissions and might qualify, but have not applied for internship approval. "This would seem to imply lack of interest in a teaching program on the part of the medical staffs of these hospitals," the report said. "This may be a major factor in the failure of a number of approved hospitals to receive an adequate number of interns."

The committee encouraged the development of internship programs by

small hospitals unaffiliated with teaching institutions, calling attention particularly to plans under which interns are shared between larger, college-affiliated hospitals and several small community hospitals. In addition, the committee found, many smaller hospitals have been successful in their efforts to develop outstanding internship programs. "The opportunity in these hospitals for the intern to assume responsibilities under supervision is often greater than in larger hospitals," the report said. "A preceptor type training with emphasis on the doctor-patient relationship and observation of the personal, human touch in practicing the art of medicine is a desirable type of training."

The committee is studying the possibility of voluntary reduction in the number of interns requested by teaching and federal hospitals, the report indicated. "In this connection, the committee believes that voluntary self-appraisal and appropriate action by all approved hospitals would result in a more equitable distribution of interns," it concluded.

Another resolution, introduced by the New York delegation, recommended that the "Contract Practice" section of the Principles of Ethics be amended in a manner "aimed at the prevention of the practice of medicine by hospitals or corporations," as Dr. Floyd S. Winslow of Rochester, chairman of the delegation, explained it. "Where an institution or organization," he explained, "contracts with physicians to provide medical service, and then collects and keeps professional fees therefor, it is, in effect, engaging in the practice of medicine. The practice of medicine must not be allowed to pass into the control of nonmedical agencies, if it is to be maintained on a level to which the public is entitled and the profession is dedicated."

WOULD ADD TO CODE

What Dr. Winslow proposed was not to make contract practice itself unethical but to add this sentence to the code of ethics: "A contract with a hospital, organization, or political subdivision which is supported in whole or in part by public funds or by solicitation of private subscribers, to diagnose and treat patients, is ethical only when such diagnosis and treatment is for a patient who is a public charge."

The Reference Committee on Miscellaneous Business, to which the resolution was referred, recommended that

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A.M.A. President-Elect

the house request the Judicial Council to investigate this and other New York resolutions, interpret the ethics and report back by next June. Without further discussion on the matter of corporate practice, the house did so.

In other actions at San Francisco, the A.M.A. house of delegates managed to uphold its public reputation for all-round high temper and, in consequence, more or less cancel out expensive efforts in recent years to present a clean public relations face.

The rush got under way on the opening day of the meeting with an official statement to the press that San Francisco hotels were treating the doctors "outrageously," when it was established that the Palace Hotel, A.M.A headquarters, and a few others had been caught short of rooms for delegates, mainly because conventioneers from the previous week had failed to check out. "Some medical politicians were forced to sleep together," one impertinent bystander observed.

Later, the National Association of Science Writers passed a resolution expressing dissatisfaction with the way the house of delegates admitted the press to its sessions and then did its best to keep reporters from ascertaining what was going on. The neatest trick of the week, however, was accomplished in the handling of the No. 1 hot chestnut of the 1954 annual meeting—what to do about the efforts to make combined billing ethical. The house adopted a report, which, in the eyes of at least two past A.M.A. presidents, closed the front door to fee-splitting while leaving the back door open. In short, the house of delegates approved of fee-splitting as far as the rendering of a joint bill by surgeon and referring physician was concerned but disapproved of the other half of the fee-splitting act, which is one doctor collecting the entire fee and paying off the other (see "Columbus Plan Begins to Roll," page 94).

At one time and another, medical ethics commanded a great deal of the 190 delegates' attention. Among the 62 resolutions considered by the house was one which produced San Francisco headlines such as "A.M.A. IN ROW OVER BAN ON PERMANENTE-TYPE PLANS." The New York delegation asked that the section on "Advertising" in the "Principles of Medical Ethics" be amended to specify that advertising for subscribers by any medical care plan which employed a closed panel of physicians would be considered beneficial to the physicians in that panel—and therefore unethical. The resolution was aimed primarily at the Health Insurance Plan of Greater New York (HIP), with its 400,000 members, but also struck at plans like the Kaiser Permanente Foundation in California, with the same number of subscribers.

SESSION WAS JAMMED

This resolution was also referred to the Reference Committee on Miscellaneous Business, of which Dr. Renato J. Azzari of New York City was chairman. Dr. Azzari first announced that the committee would consider the resolution in executive session, thereby excluding reporters and a large number of interested doctors, including some official delegates. The latter left, claiming, "I was kicked out," and, "I'm going to fight this thing out on the floor." As a result, Dr. Azzari quickly changed his mind and declared the meeting open. Thereafter it was not only open but jam-packed. Dr. Russel V. Lee of the Palo Alto Clinic pointed out that the California Physicians Service, operated by the California Medical Association, advertises for subscribers on billboards. He argued that it would be unjust to other groups to forbid them to do the same. Eventually the committee, and subsequently the house of delegates, referred the whole question to the Judicial Council for interpretation and action next year.

The New York delegation fared better on a recommendation that proration of the fee be considered ethical in cases where two or more physicians render medical and surgical care and an insurance company pays a fixed

total fee. It was specified that the bill would be for legitimate service, in proportion to service rendered, and would be itemized so the patient could see what was going on, so the proposal "has obviously nothing to do with the legitimatizing of fee-splitting, as has been charged."

This recommendation was referred to the Judicial Council which already had brought in a report proposing substantially the same method under the term, "joint or combined billing." This report was adopted, making combined itemized billing ethical.

In addition to a redefinition of fee-splitting, the Council on Constitution and By-Laws, of which Dr. Louis A. Buie of Rochester, Minn., is chairman, proposed other changes in the "Principles of Medical Ethics," and these were adopted by the house:

"It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients cannot procure from other sources.

"The acceptance of rebates on prescriptions and appliances or of commissions from those who aid in the care of patients is unethical.

"The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

"An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such law."

On the recommendation of the board of trustees, the house adopted a report of the two-year old Committee for the Study of Relations Between Osteopathy and Medicine, putting over until December the fateful decision of whether to count doctors of osteopathy in or out of the medical profession while endeavoring to get more than indirect evidence in taking their measure. The report read in part:

"The justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools. The committee, therefore, proposed to the Conference Committee of the American Osteopathic Association that it obtain permission for the Committee

(*Continued on Page* 158)

Michigan Hospital Association Files Brief in Ironwood Hospital Appeal

LANSING, MICH.—A license to practice medicine in the state does not guarantee the right to practice in a public hospital, regardless of hospital rules, and such rules may be made for the protection of patients, the Michigan Hospital Association asserted in a brief presented to the state supreme court here last month. The association brief was presented in connection with the case of the Grand View Hospital at Ironwood, Mich. *vs.* Dr. Samuel G. Albert, Ironwood physician, who sued the hospital when he was dropped from the staff for violation of hospital rules.

A circuit court decision in favor of the plaintiff physician is on appeal to the supreme court, and the Michigan Hospital Association's *amicus curiae* brief was filed last month by Warner & Hart, association attorneys.

The association contested the circuit court's decision that the right to practice medicine carries with it "the absolute right to practice in hospitals." Reviewing several similar cases in which courts upheld the hospital's right to exclude physicians, the association brief stated: "We find no language in the Medical Practice Act suggesting that a license to practice medicine carries with it a vested right to practice in hospitals. That act does not provide any right to suspend or revoke anything except the license to practice medicine. The lower court's premise that the right to practice medicine carries with it a vested right to practice in hospitals is not supported by citation, and is contrary to established law."

The brief also held that hospital rules were made for the protection of life and health of hospital patients. Citing the opinion of an Illinois appellate court in 1942 that hospital rules restricting privileges to qualified staff members were reasonable, the brief pointed out that the Illinois court had said: "The rule in controversy is fundamentally a provision for the public safety and the public welfare. It is in no sense for the personal benefit of the hospital or the board of directors except in maintaining the standard of excellency and proficiency contemplated by the statute and required by the welfare of the public."

In the Ironwood case, the Michigan Hospital Association stated, hospital rules were plainly reasonable and in the public interest. "We think that denial of hospital privileges to Dr. Albert until he should comply with hospital rules which were enforced against other doctors was clearly within the right and duty of the board," the association brief said. "This course of action seems all the more justified in view of Dr. Albert's refusal to attend the meeting to show cause why his hospital privileges should not be revoked," the brief added, referring to the plaintiff physician's refusal to cooperate with hospital rules regarding incomplete records and questionable surgical procedures. (See "Medical Anarchy in Ironwood," by Greer Williams, The MODERN HOSPITAL, April 1954.)

Concluding its brief, the Michigan Hospital Association urged:

1. That the right to practice medicine in the state is not a license to use the facilities of a public hospital regardless of hospital rules.
2. That the defendant public hospital had a right and duty, through its board, to prescribe rules for the protection of the life and health of patients.
3. That the rules and regulations made by the hospital board were designed and did operate to protect the life and health of patients.
4. That the decree of the lower court should be set aside and Dr. Samuel G. Albert should be required to practice in the defendant hospital only after complying with the same regulations imposed on other practitioners using the same facilities.

In the pavilion record room doctors work at built-in counter. Librarian's desk is in the foreground.

Reversing the usual procedure—

The Record Room Goes to the Doctor

ALVIN HAMBURG
Resident in Hospital Administration
Cedars of Lebanon Hospital, Los Angeles

CEDARS of Lebanon Hospital, Los Angeles, developed a "come as you are, self-service" medical record room when its new maternity and pediatrics pavilion opened early in 1953. In the past the staff physicians, although cognizant of the great importance of records, often found it difficult or inconvenient to visit the central record room located in the main building. This motivated the hospital to bring "the mountain to Mohammed" by placing a pavilion medical record office in the obstetricians' lounge and sleeping quarters area.

A medical record librarian assistant, with several years' experience in the central record room, was assigned full time from 8 a.m. to 4:30 p.m. Monday through Friday. This was expected to meet the load of a new unit with 90 maternity beds, 96 bassinets, and 35 pediatric beds. Although the pavilion operated below capacity for some time, approximately 2500 babies were born and more than 700 pediatric cases were cared for during the past year.

The pavilion record librarian is directly responsible to the chief medical record librarian and has daily conferences with her. It is interesting to note that the members of the obstetric and pediatric record committees of the staff have a great deal of personal contact with the pavilion record librarian, work closely with her, but do not exercise any supervisory or administrative control over her position.

The pavilion record room is 15 feet long by 11½ feet wide. It has a 15 by 2 foot built-in work counter that can accommodate four persons easily. Above the counter are open shelves where records can be placed.

Each physician has his own personal folder that contains all of his incomplete records. These folders are arranged in alphabetical order, in a visible file, on a 5 by 3 foot table outside the door to the office. Inasmuch as the office is not locked, all records are available on a 24 hour basis. Access to the area is restricted to doctors and is reached by elevator.

The first, and very necessary, step in the process of collecting medical statistics is a complete and accurate record. One of the time consuming jobs in the process is checking and assembling the records and then notifying the physician to bring the record up to date. Notification of the obstetri-

cian has proved to be quite easy because he must pass the pavilion record room en route to his dressing quarters.

Occasionally a physician is not very active and his records begin to accumulate. Then the medical record librarian calls his office. In addition, a weekly list of delinquent charts is sent to the main record room for transmittal to the superintendent's office. If any member has a substantial number of delinquent charts, he is reminded of his delinquency by the chief of the service. This has occurred only twice in the past year.

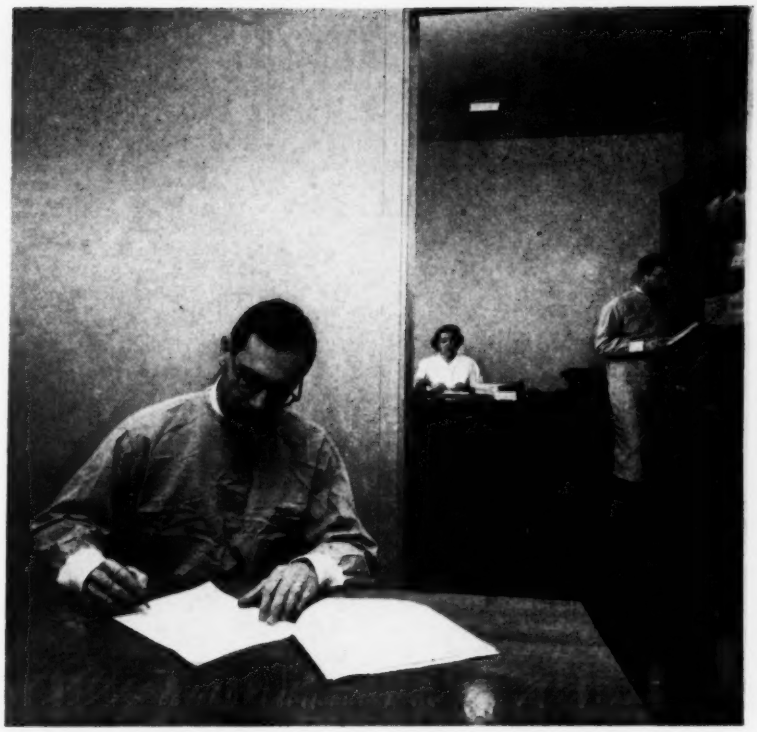
Pediatricians could offer more of a problem than they do inasmuch as their quarters are on the first floor while the pavilion record room is on the fourth. Their performance has been quite adequate although no extra effort has been made to keep in regular contact with them.

Once the librarian is satisfied that the chart is complete and in good order she places it on a shelf where it is available to the editing pediatric and obstetric record committees. These three-man committees, appointed by the respective chief of the service, edit all records before they are finally processed in the record room. Generally the records are edited and approved by only one committee member at a time. The committee work has been up to date consistently, primarily because the work can be accomplished while the physicians are awaiting deliveries.

By means of written memoranda and personal contact the committee member informs the individual obstetrician or pediatrician of specific report deficiencies. Thus without any formal medical audit a constant review of medical care is being maintained. In addition, editing serves to standardize reports and to make them more useful for teaching and research.

If the record is satisfactory and the editing committee does not have any further corrections to recommend, the record is initialed and returned to the medical librarian. She does the usual standard nomenclature coding and enters the classification on her card index files.

The proximity of the record room to the delivery room is of mutual benefit to the librarian and the physician. Inasmuch as all cesarean sections and therapeutic abortions must be reported, the doctor can dictate his findings to the librarian immediately after the operation. In addition she can fill in medical record omissions by referring directly to delivery room records and thus save the doctor extra trips. False labor charts are brought directly to the pavilion record room because the patient does not occupy a bed on the maternity floor.



View into the pavilion record room. The physicians' work desk with the visible file of incomplete records is contiguous to the entrance. At right, a staff member studies record he has taken from the built-in shelves.

The pavilion medical record librarian shares her office with the resident in obstetrics. He is concerned with the monthly statistics and prepares a monthly report for the attending obstetricians. This serves to make the staff more record conscious. The record librarian also helps to coordinate his work.

All charts of pediatric patients housed in the pavilion are analyzed by the pavilion medical record librarian. Orthopedics, E.N.T., and similar services that deal with both children and adults have the chart analyzed where the patient is housed.

Completion of insurance forms for obstetrics and pediatrics cases is also the responsibility of the pavilion medical record librarian. These originate at the business office and are funneled to the record room.

An interesting development is that clinic outpatient prenatal records are kept on file in the pavilion record room. This record is available to the clinic for the outpatient treatment of the mother and is also immediately available when the mother comes in for delivery. All completed pavilion records are transferred to the main record room for permanent filing, however.

Among the routine reports the librarian develops from the daily reports are: the monthly analysis of service (for the central record room), an annual report of maternity and newborn deaths (for the state department of health), and an annual departmental report of normal and section deliveries.

The medical staff's enthusiastic response to this new approach by Cedars of Lebanon Hospital is encouraging. It ensures that the accuracy and completeness of medical records will be equal to the prevailing high standards of obstetric and pediatric care that are offered. In addition we find that the staff is making more extensive use of the statistical data that are now so easily available.

PROTOTYPE STUDY: 600 BED HOSPITAL

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THIS hospital type is generally located in a metropolitan center. It is usually a teaching hospital and is more often than not connected with a medical school. It usually caters to a large group of indigent patients.

BED DISTRIBUTION

Major. In more than half of these hospitals, medical, surgical, obstetrical and pediatric patients have beds specifically set aside for their use. For this reason they are considered as major services in such a type and size group. Medical and surgical services combined account for approximately 75.8 per cent of all beds, obstetrics for 12.5 per cent, and pediatrics for 11.7 per cent. This means that the average 600 bed general hospital has 455 medical and surgical beds, 75 obstetrical beds, and 70 pediatric beds. It is difficult to segregate medical and surgical beds because it is common practice to have combined medical and surgical nursing units as well as separate units.

The bed distribution by type of accommodation may vary considerably, dependent upon the indigent relationships. Ward beds, however, usually account for more than 50 per cent of all available beds. The usual distribution may be 17.5 per cent private (1 bed rooms), 25 per cent semiprivate (2 bed rooms), and 57.5 per cent ward (multiple rooms). This means that the average 600 bed hospital would have 102 private beds, 150 semiprivate beds, and 348 ward beds.

The foregoing bed distribution will be affected by assignments to additional services discussed hereafter.

Additional. In addition to the four basic groupings of patients in more than half of these hospitals, the 600 bed general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional services. Table 1 indicates these additional services, their frequency of occurrence and average number of beds assigned to them.

Bassinet Distribution. The average number of bassinets for newborn is the same as for obstetrical beds, 75.

UTILIZATION

The kind, type and number of patients admitted during the year to the 600 bed general hospital are:

Admissions. An average of 17,000 patients is admitted during the year, averaging 28 admissions per bed, per year.

Births. There are approximately 3100 live births during the year. Of this number, 175 to 180 will be premature. There will be approximately 30 sets of twins and 2 sets of triplets during the year. There will be about 35 stillbirths during the year.

Deaths. There are approximately 640 deaths during the year, 445 to 450 of which are institutional deaths (deaths occurring 48 hours or more after admission), and 190 to 195 are noninstitutional (deaths occurring within 48 hours after admission).

The gross death rate (total deaths divided by discharges) is around 3.9 per cent. This means that almost 4 out of every 100 patients discharged die in the hospital.

The net death rate (institutional deaths divided by total discharges) is around 2.7 per cent. This means that almost 3 of the 4 deaths occurring in the hospital are considered as institutional deaths.

There were approximately 29 to 30 premature fatalities during the year.

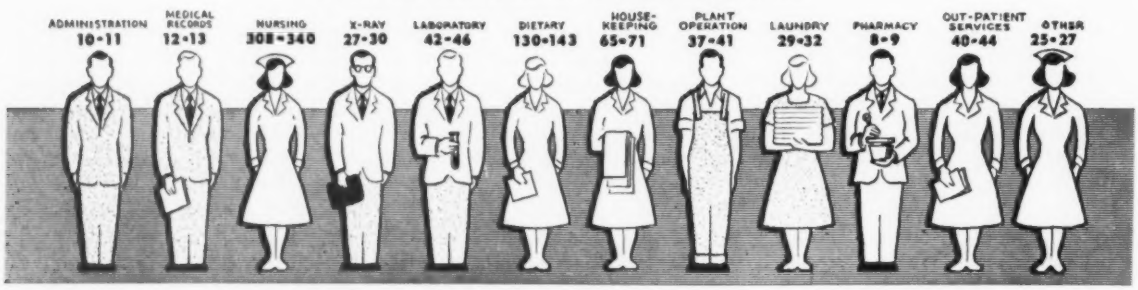
Autopsies. An average of 370 autopsies is performed during the year. This

This is seventh in a series of prototype developments. The first six articles of the series were: "The 50 Bed Hospital," June 1953; "The 100 Bed Hospital," October 1953; "The 200 Bed Hospital," January 1954; "The 25 Bed Hospital," February 1954; "Prototype Summaries, 25 to 200 Bed Hospitals," June 1954, and "The 400 Bed Hospital," July 1954. The reasons for the development of this series were explained in some detail in the first article.

Table 1—Frequency of Additional Services

Patient Group	Frequency of Occurrence	Avg. No. Beds Assigned
Isolation of contagious	3 in 10 hospitals	22
Nervous and mental	1 in 3 hospitals	78
Tuberculosis	1 in 6 hospitals	35

AVERAGE NUMBER OF PAID PERSONNEL *



* Additional categories of personnel employed in the 600 bed hospital are listed in the section on Personnel, pages 69 and 70.

shows an autopsy rate of 58 per cent (autopsies divided by deaths).

Patient Days of Care. The hospital provides around 187,500 days of care during the year. Of this number approximately 18 per cent are private days, 27 per cent, semiprivate days, and 55 per cent, ward. This means that 33,750 days are for private patients, 50,625 for semiprivate patients, and 103,125 for ward patients.

Newborn Infant Days of Care. In addition, approximately 19,000 days of care are provided for newborn infants during the year.

Average Daily Census. An average of 513 patients is cared for in the hospital daily. Of this number, 91 are private, 140 are semiprivate, and 282 are ward patients.

An average of 52 newborn infants is cared for daily.

Percentage of Occupancy. The average annual percentage of occupancy approximates 85.5 per cent, varying from 90 per cent for private patient accommodations to 95 per cent for semiprivate accommodations, and 80 per cent in ward accommodations.

Newborn occupancy approximates 69 per cent.

Average Length of Patient Stay. Length of patient stay averages 11 days.

This varies by type of accommodation as follows:

Private	10-11 days
Semiprivate	9-10 days
Ward	14-15 days

Length of stay for all patients varies by diagnosis as follows:

Medical	17-18 days
Orthopedic	16-17 days
Genito-urinary	14-15 days
Surgical	11-12 days
Ophthalmology	11 days
Pediatric	9-10 days
Gynecology	8-9 days
Other medical	8-9 days
Obstetrics	6-7 days
E.N.T.	1-2 days

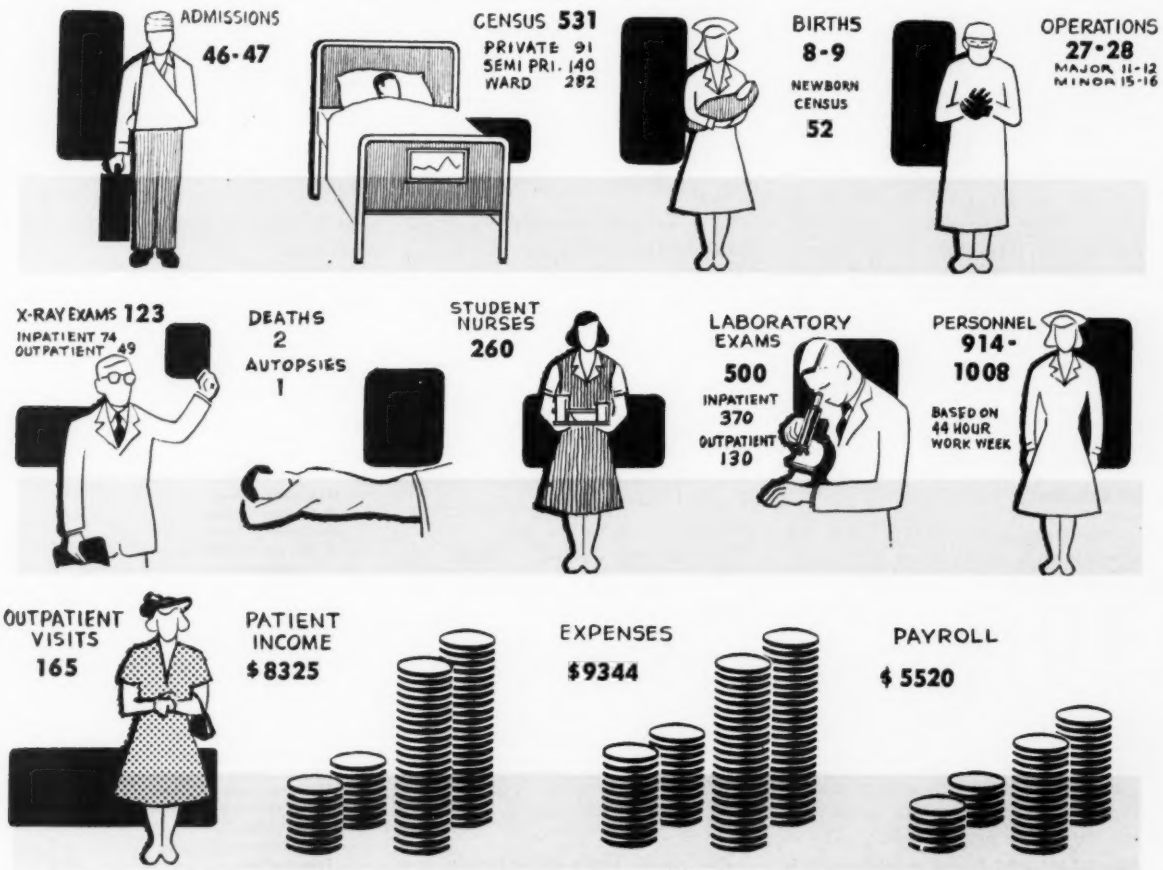
PERSONNEL

Numbers. The average number of paid personnel approximates 1000 to 1100 excluding interns, residents and students.

This amounts to an average of 188 to 207 full-time employes per 100 patients; 1.9 to 2.1 employes per occupied bed, and 1.7 to 1.8 per bed.

By Department	*Employes*
Administration	10-11
Business office	62-66
Purchase and storage	14-15
Plant operation	37-41
Maintenance of buildings and grounds	29-32
Laundry	29-32
Linen and sewing	11-12
Maintenance of personnel	48-53
Housekeeping	65-71
Dietary	130-143
Nursing	308-340
Graduate	158-175
Other	150-165
Nursing education	20-22
Operating rooms	40-45
Delivery rooms	15-16
Anesthesia	10

AN AVERAGE DAY'S ACTIVITIES * *



In this prototype of hospital operation for the 600 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

** Additional activities performed on an average day in the 600 bed hospital are listed on page 70.

X-ray diagnosis and therapy	27-30
Laboratory	42-46
Pharmacy	8-9
Physical therapy	6-7
Medical records	12-13
Social service	15-17
Outpatient department	40-44
Emergency	7-8
Other personnel	25-28
Total	1000-1100

SERVICES

Major. The following services are found in more than half of the existing 600 bed general hospitals.

Services	Per Cent
Blood bank	100
Cancer clinic	56
Central supply	100
Clinical laboratory	100
Dental department	89
Electrocardiograph	100
Electroencephalograph	67
Medical library	100
Patient library	89
Medical record department	100
Basal metabolism	100
Occupational therapy department	56
Outpatient department	100
Pharmacy	100
Physical therapy department	100
Social service department	67
X-ray diagnosis	100
X-ray therapy	100
Women's auxiliary	67
Routine chest x-ray on admission	57

Additional. Services that might be provided but are generally found to occur in fewer than 50 per cent of the facilities are considered as additional. The following indicates some of these services and the frequency with which they are provided within this size and type group.

Services	Per Cent
Children's educational program	28
Mental hygiene clinic	40
Postoperative recovery room	30

DEPARTMENTS

Outpatient Department. There are approximately 60,000 visits to the outpatient department during the year. There is usually a ratio of 3 free visits to 2 pay and part-pay visits.

Emergency Service. There are approximately 16,000 emergency visits during the year. Approximately 9 per cent of these are admitted as inpatients.

X-Ray. There are approximately 15,000 x-ray examinations given during the year. Approximately 37,350 patients are seen (ratio of 16.6 patients to 20 examinations).

The ratio of inpatient examinations to outpatient examinations is 3 to 2. This amounts to about 27,000 examinations for inpatients and 18,000 for outpatients.

Average number films per examination is 2.5, or 112,520 films.

Virtually all of the hospitals have physician staff members specializing in radiology. They are usually full-time employes.

Almost all of the hospitals have x-ray facilities available to private ambulatory patients of physicians.

There are approximately 4000 therapy treatments given during the year.

Laboratory. Approximately 180,000 clinical laboratory examinations are performed annually.

The ratio of inpatient examinations to outpatient is approximately 3 to 1. This amounts to 135,000 for inpatients and 45,000 for outpatients.

Virtually all of the hospitals have physician staff members specializing in pathology. They are usually full-time employes.

Virtually all of the hospitals have all tissue removed in surgery routinely examined by a pathologist.

Operating and Delivery Rooms. The average number of operations approximates 10,000 for the year. There are approximately 10 operating rooms.

The ratio of major to minor operations is 3 to 4. This amounts to about 4300 major and 5700 minor operations per year.

There are approximately 3 delivery rooms and about 3100 deliveries during the year.

Electrocardiograph. There are approximately 7500 electrocardiograph examinations performed during the year.

Electroencephalograms. There are approximately 400 electroencephalograms performed during the year.

Physical Therapy. There are approximately 34,000 physical therapy treatments given during the year.

Occupational Therapy. There are approximately 4725 occupational therapy visits during the year.

Basal Metabolism. There are approximately 700 basal metabolism tests performed during the year.

Anesthesia. There are approximately 10,000 anesthesias administered during the year.

Blood Bank. There are approximately 2750 blood transfusions given during the year.

Pharmacy. There are approximately 165,000 prescriptions filled during the year.

Medical Staff. There are approximately 65 interns and residents.

Nursing Education. There are approximately 260 student nurses.

Dietary. An average of 1,080,000 meals is served annually. Approximately 560,000 are for patients and 520,000 for personnel and others.

Laundry. About 2,400,000 pounds of laundry are processed during the year. Virtually all these hospitals have laundries. Those that do average 20 to 21 hospital beds per laundry employe.

FINANCIAL

Assets. Total assets per bed amount to about $11,000 to $12,000 per bed.

Plant assets per bed approximate $7000 a bed or about seven-twelfths of total assets.

Expense. Expenses approximate $3,400,000 to $3,500,000 per year. The average expense per patient day amounted to $18 to $19. Average expense per patient stay amounted to $198 to $209.

Pay Roll. Average annual pay roll amounted to almost $2,000,000. Average pay roll amounted to between $10 and $11. Pay roll amounted to 58 per cent of expense.

Income. Patient income for the year approximated $3,000,000. This amounted to between $16 and $17 per patient day. Income amounted to $176 and $187 per patient stay. Patient income amounted to 89 per cent of expense.

AN AVERAGE DAY'S ACTIVITY IN THE 600 BED HOSPITAL

Admissions	46-47
Births	8-9
Deaths	2
Autopsies	1
Census	513
Private	91
Semiprivate	140
Ward	282
Newborn census	52
Outpatient visits	165
Emergency visits	44
X-ray examinations	123
Inpatient	74
Outpatient	49
Laboratory examinations	500
Inpatients	370
Outpatients	130
Operations	27-28
Major	11-12
Minor	15-16
Electrocardiographs	21
Physical therapy treatments	93
Occupational therapy visits	13
Basal metabolism tests	2
Electroencephalograms	1-2
X-ray therapy treatments	10-11
Anesthetics	27-28
Transfusions	7-8
Prescriptions	452
Personnel (44 hour week)	917-1008
Student nurses	260
Residents and interns	65
Patient income	$8325
Pay roll	$5520
Expenses	$9344

Methods Improvement Is Management's Job

The administrator is responsible for instigating the methods improvement program—and implementing it

RAY E. BROWN
Superintendent, University of Chicago Clinics

SUCCESSFUL management can quite properly be defined as restless management. A continuing methods improvement program is a symptom of the perpetual dissatisfaction, with even the best of accomplishments, that characterizes outstanding management. The basis of methods improvement is the philosophy that perfection is never reached and that there is always room for improvement. Every administrator utilizes the principles of methods improvement at times. Too often, the times are when a service has deteriorated to such an extent as to require a complete overhauling. This sporadic attention to methods falls far short of systematic management and assures improvement only at the margin of failure.

MANAGEMENT IS RESPONSIBLE

Methods improvement requires that management accept definitely the responsibility for methods. It does not deny the ingenuity of the average worker in developing on his own better and easier ways of performing the task assigned to him. It recognizes, however, that often the worker learned his job by word of mouth from his associates and that precedence and habit are strong handicaps to change. More important, it recognizes the lack of control the worker possesses over the sequence of procedures in which his own job fits, the materials and equipment he uses, and the physical layout in which he works. Because management does have the dominant voice in determining the content and environment of the jobs within the hospital it is up to management to play the leading rôle in improving the jobs.

The principles used in methods improvement are logical and are applied in part, or in whole, by hospital administrators in numerous situations. These principles are described by different authorities under different terms, but can in general be listed as follows: (1) Define the purposes of the activity to be examined and determine its relationship to other activities in the hospital; (2) divide the activity into its component jobs and examine the relationship of each job to the others within the activity; (3) break down each job in detail and determine if each detail is necessary; (4) examine the effects that equipment, supplies and layout have on each job; (5) reconstruct the activity in keeping with the findings and reexamine the work distribution to determine if work is distributed properly and if skills are used properly.

The tools of methods improvement as used by the professional industrial engineer sound impressive and slightly frightening. The professionals speak of flow charts, process charts, operations analysis sheets, and micromotion instruments. Actually, most of the tools are sensible devices for systematically recording pertinent data. The use of these tools, however, is not indicated in an examination of most of the methods inherent in hospital operations. Much of the work of the hospital will not yield too much result from detailed motion studies. Where motion studies are indicated it might be best to enlist professional aid. The greatest gains in the hospital will be found in an examination of those factors that are environmental to the motions rather than from an examination of the precise motions themselves. Most often very satisfactory results will be achieved by the simple device of listing in order of performance each job of an entire activity, or system, and every function of each job.

It is the use of the information, rather than the technic of gathering it, that produces results. The information obtained should be used to subject the particular activity, and every job within it, to the burden of defending itself against possible elimination, or possible combination, or possible rearrangement. The question of elimination of many of the activities now carried on by hospitals may well be the most fruitful source of economy and improved patient service. The entire hospital field suffers from the paradox of small scale enterprise attempting to be self-sufficient. In competitive industries only the largest firms dare the extent of integration practiced by even the smallest of hospitals. The fact that hospitals do not in general have to compete on the basis of price has encouraged them to continue functions that were developed when such services could not be purchased satisfactorily from outside producers.

USE CONTRACT SERVICES

Outstanding examples of this practice are the many small hospital laundries; the failure of hospitals to use ready-made prepackaged dressings, and the refusal of many hospitals to perform such routine functions as window washing on contract. The decision to purchase service cannot, of course, be based entirely on cost and must take into account all the effects on patient care. It is just this point that argues strongest for the purchase of any service that can be satisfactorily produced outside the hospital organization.

The combination and rearrangement of activities and jobs represent the difference between the worker's having tailored assignments fitted to the needs of the organization and his special training rather than hand-me-down as-

signments. It is an orderly effort to utilize the highest skills of each worker to the largest extent possible. Proper job composition attempts to specialize each worker's assignment as much as possible, not only to decrease learning time, but to minimize time lost in changing from one task to another. It takes care to distribute the work evenly so as not to overburden and at the same time not to spread the work too thinly. It recognizes the fact that workers pace themselves according to the requirements of the job.

The principles and tools of methods improvement are not the difficulty in setting up a methods improvement program. The major difficulty is the development of an organizational attitude from the administrator straight through the organization that reflects a belief that every job is important and that continued, systematic study of each job can increase productivity for the hospital and achieve better working conditions for the personnel. This is a difficult attitude to develop and sustain because it requires enthusiasm, energy and time. It requires attention to subject matter that is not dramatic and a willingness to buck the habits and work patterns that have existed, perhaps with satisfactory results, for a good many years longer than the average administrator's own tenure in the organization. It means the courage to question some of the work methods of the several professional groups within the hospital personnel structure. If the program of methods improvement is to mean more than a mental exercise to the organization it requires on-the-job training of each employe, the training of supervisors, and a planned program of follow-up. All are necessary to assure that the new methods are followed and that the cloak of inattention does not cover a gradual replacement of the rationally developed methods by the employes' own rule-of-thumb approach to their jobs.

Hospitals have several important characteristics that handicap their maximum utilization of methods improvement. Most hospitals are small and cannot departmentalize their operations so as to create the best climate for strong supervision. Even though they are small these hospitals must carry out more different functions than most industrial firms do. This means the small hospital cannot in most respects specialize its labor and simplify the number of duties an employe must learn. On the contrary most employes of the small hospital are required regularly to handle multiple duties.

The hospital is a personal service industry and only a minority of its jobs are repetitive in nature. For this same reason it does not have too many opportunities to employ machines as a substitute for the worker. This means it loses the opportunity that much of industry enjoys for improving methods by building better methods into the machine. Much of the hospital's service is performed by professional groups who are reluctant to change professional ways. The service of the hospital is delivered at the request of individual members of the medical staff, each trained differently and each with his own ideas as to proper procedures and proper supplies and instruments. There are numerous other factors that inhibit methods improvement in the hospital. About any two of them could give the harried hospital administrator sufficient excuse to continue to let things come naturally rather than by systematic management.

Obviously, the handicaps to methods improvement must be overcome if hospital administration is going to demonstrate competence equal to that of other forms of management in increasing efficiency and combating costs. This requires a planned and continuous program. There are several alternatives a hospital might take in establishing and maintaining such a program. One

Methods Studies Aim at Better Design

A MODERN HOSPITAL ROUND TABLE

THIS is the second section of the round table discussion of methods engineering studies conducted in Cleveland. Participants included: Dr. Fred G. Carter, vice president and trustee, St. Luke's Hospital, Cleveland; Guy J. Clark, recently retired as executive secretary, Cleveland Hospital Council; Kenneth Shoos, administrator, St. Luke's Hospital; Earl J. Frederick, methods engineer, and Dr. Frank Sutton, administrator, Miami Valley Hospital, Dayton, Ohio. Everett W. Jones was the moderator.—Ed.

MR. CLARK: Won't methods engineering also eventually have a considerable effect upon the planning of hospitals? Won't we plan our new hospitals on the basis of what we find in the various factors under study so that they will be planned from a functional standpoint to save time and do things in a better way?

DR. CARTER: Well, along that line, I've thought a lot about what we, for want of a better term, call multiphasic screening. When a patient comes into a hospital he is assigned to a bed, and then you start a procession of technicians and the Lord knows who else running to the bedside, each one an individual trip perhaps. Maybe they combine some of them, but why shouldn't all this work, or most of it, be done as the patient comes into the hospital? In other words, make your admitting department much more effective and much more elaborate than it is now. Why not do urine analysis? Why not do blood counts? Why not do them all in the same general geographical location?

MR. JONES: The idea, then, is to save the technician's time, to prevent his having to run all over the hospital to find new patients.

alternative would be the utilization of one of the several methods engineering firms. This choice has the important defect of being sporadic rather than continuous. It does not provide implementation except at substantial cost. Even on a purely consultive basis it is expensive. There is, however, a definite rôle for such consulting firms in any program of methods improvement within the hospital. Whatever the particular hospital's own setup, it can profit from intensive studies by outside professionals of those hospital departments whose work is repetitive and primarily sequential in nature. The fact that such firms are not entirely familiar with hospital ways is not too important. The principles are the same whenever applied. This lack of knowledge may be a good thing if it means that they can overcome the barrier of tradition that inhibits an inside effort from changing. There may also be some truth to the saying "the best way to get the inside story is to call in an outsider."

The use of an outside firm can never be more than supplementary to the hospital's own organized program. Only through concerted, organized effort on the inside is there hope of developing an organizational climate for implementation of and persistent and continuous effort toward methods improvement. Two different approaches have been tried by hospitals in setting up organized programs within the framework of the hospital. One approach has been to bring in an experienced methods engineer and give him training in hospital management. The other approach has been to select an experienced assistant administrator and have him take special training in methods engineering. Both approaches have produced good results in the initial stages and served to stimulate strong interest in the program throughout the hospital. However, sufficient time has not elapsed in any of the hospitals to determine whether a competent assistant administrator can be kept sufficiently free from other pressing administrative duties to direct a functionalized methods department over a period of years. The inclination of an assistant administrator in such a position will probably be toward seeking more and more operating responsibilities for two strongly personal reasons: The operating responsibilities have much more day-to-day appeal and also offer much greater opportunity for professional development. Only the largest hospitals will be able to justify to their boards an additional assistant administrator hired specifically for this purpose and, consequently, the career opportunities of the person specializing in methods improvement will be quite restricted.

Because most hospitals are small and do not have an assistant administrator the answer to the problem will have to be found in the existing organizational structure. That may well prove to be the best answer in even the largest hospitals for it will mean the program will have permanence because it is organically imbedded in the operating structure. Too much emphasis cannot be given to the necessity of planning the program so as to assure permanence. The greatest gains will be the long-term gains of continuous examination and improvement. Over-selling as regards immediate gains, or over-zealousness and revolutionary changes, will result in disinterest because of unrealized expectations, or reactions of strong antagonism because of the damage created. We can take our lesson from the disrepute into which the early programs of scientific management fell during the 1920's and 1930's because of the plethora of experts whose unfulfilled promises disillusioned management and created great ill-will and lasting suspicion on the part of labor.

(*Continued on Page* 74)

DR. CARTER: Yes. The one thing we have to give the most consideration to and build the whole hospital on is traffic.

MR. JONES: If you could get all of the routine procedures called for by hospital rules done before the patient ever gets up into his room, you would speed up the whole diagnostic procedure and that might cut the length of stay and therefore reduce the bill.

DR. SUTTON: I have heard it said that if they could cut the hospital stay in Philadelphia by half a day they could save more than a million dollars a year. I think that by screening patients as they come in you could often save as much as a whole day or even more.

MR. JONES: Mr. Clark brought up a very important point when he said these methods engineering studies will have a profound effect on the design of hospitals. Actually, we are seeing that happen right now in the famous old Peter Bent Brigham Hospital in Boston, where Dr. Carl Walter, working with Dr. Norbert Wilhelm, the administrator, and the industrial engineers and architects, Markus & Nocka, have completely redesigned the old wards and the operating rooms. Their whole concept of many things they used to think were necessary has now gone by the boards. The design of the Kaiser-Permanente hospitals, too, is a complete departure from the standard type of nursing station.

MR. CLARK: Dr. Carter, would you tell us what you think is the value of group participation in reviewing plans, such as we've done in Cleveland on our expansion program in the last few years? I think it's been helpful, not only to the hospitals but to all who participated.

DR. CARTER: Well, of course, there are economies involved in it for one thing. What we have here is a committee that passes on the plans of all hospitals being built in the area. We started as a result of the organization of Greater Cleveland hospitals.

MR. JONES: This is a voluntary committee?

DR. CARTER: This is a voluntary review committee and there's a subcommittee of administrators that reviews the plans. We go over them and find flaws in traffic arrangement and other things, and it has resulted in a lot of good suggestions arising from the experiences of these administrators who sit in on this committee.

MR. JONES: You're pooling the knowledge and experience of a number of administrators to help each individual administrator.

DR. CARTER: That's right. We started with the Greater Cleveland group sometime in 1945 and we can't let go of it now, because the hospitals, as they draw up plans, ask the committee to criticize them.

(*Continued on Page* 130)

To assure a permanent and organized program of methods improvement it will be necessary that the hospital not only imbed the program in its organizational structure but also that it attach the program to its administrative routine. This can be done in even the smallest hospital on the following plan.

1. Responsibility for direction of the program must be accepted by the administrator in the small hospital, or assigned to assistant administrators in a large hospital on a basis of each assistant's being responsible for direction of the program for those departments which are his direct responsibility. A practice should then be developed of reviewing the details of each job in the particular activity concerned when any of the circumstances listed below occurs. The establishment of such a practice makes methods improvement a part of the administrative routine and assures that it will be done on a continuing and planned basis.

IT SOLVED A PROBLEM

When new equipment is requested. A rather dramatic illustration of the results that can come from routine reappraisal of methods at the time a request for new equipment is received occurred in our own institution. Several years ago the blood bank requested a large specially constructed refrigerator for storage of plasma. At this time it was decided to review the entire question of plasma processing and storage. This review, directed by a clinician who continues to serve as consultant for the blood bank, revealed no reason plasma could not be stored on shelves at room temperature. This methods study not only resulted in substantial savings but the follow-up on this new method provided the clinician with the idea and the data to show conclusively that storage of plasma at room temperature solves the serious problem of transmission of infectious hepatitis through plasma.

Request for additional personnel. A neighboring hospital administrator with an active methods improvement program just recently told of a time-saving change in methods in his institution accomplished by following up a request for an additional employe in central supply. The review showed that sterile packs were being wrapped twice in two separate actions. Study of the procedure brought about a new method of sewing the two pieces of muslin, used as wraps for such packs, together around the edges, and consequent elimination of one of the two duplicating actions.

When alterations to the physical plan are requested. It was because of a request for rearrangement and expansion of a linen storage room on the nursing floor that the idea of a compartmented linen storage truck was developed. The former method involved loading the linen on a portable hamper in the laundry, transporting the linen to the floor, sorting the linen onto the linen room shelves, and use of the linen off the shelves. The new method reduced the handling by having the laundry sort the linen into compartments on a specially constructed cart, moving the cart to the floor, and using the linen directly from the cart. An additional advantage was the decrease in linen inventory gained by moving all unused linen back to the laundry when a newly loaded cart is sent up as an exchange.

In case of major or repeated complaint regarding service. The need for reappraisal of methods in these circumstances is perhaps universally recognized. These are the circumstances under which methods examination becomes almost compulsory. The tendency in this connection is to treat the symptom rather than do a comprehensive examination that includes all procedures within the activity concerned with the complaint. A full-scale examination will not only help improve the immediate reason for the defect in service, but will iron out contributing causes of impairment and later disruptions in this same service.

2. Department heads should be schooled in the principles and technics of methods improvement. This can best be accomplished through demonstrations of actual situations and by persons or agencies outside the particular hospital. The American Hospital Association is seriously studying this problem and it is to be hoped that a definite program of institutes on methods improvement will be undertaken by the association in the near future. Such a program should provide specific institutes for each department of the hospital so as to demonstrate possible applications and to press home the fact that methods improvement is practical for a particular department. The institutes on methods improvement should be entirely separate from, and additional to, the existing departmental institutes which cover the many other facets of departmental operation. Needless to say, hospital administrators should urge department heads to attend these institutes, if possible at the hospitals' expense.

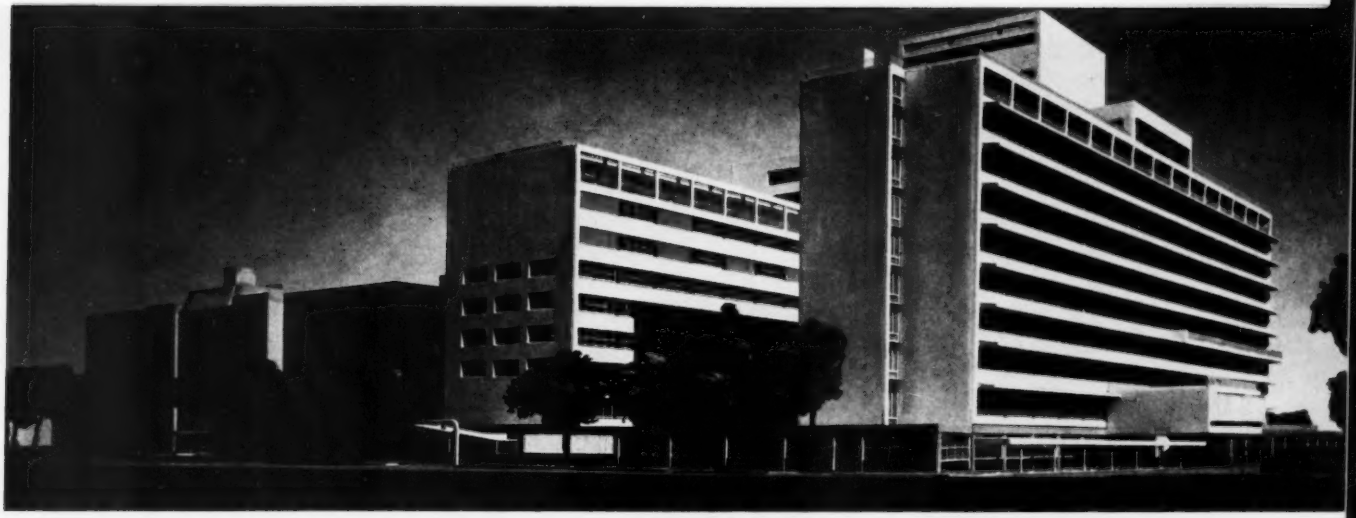
3. Every hospital should utilize outside methods engineering firms periodically for special study of a particular activity or system within the hospital. These special studies should be well defined and restricted to a definite activity or system. It will do little good to the hospital or the methods program to turn an outside methods firm loose on a fishing expedition in the hospital.

IMPORTANT OVER-ALL GAINS

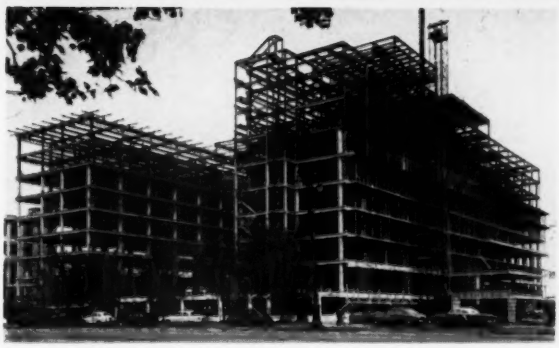
Aside from the improvement that might come to the particular activity from a well defined and specific study, there are important gains to the hospital as a whole. Initially, it would help with the indoctrination of the organization as to the importance of the methods program and serve as a training device. Over the years, as other special studies were made, it would inject new meaning and new life into the program. It would also convince the board and the community that the administrator welcomed advice and help from outside sources. It could be, too, that the outside methods firm could help the administrator put across changes that the administrator has desired but not dared.

Other avenues for obtaining the services of professionally trained methods engineers are available to many hospitals. One important source is the many universities and colleges that have industrial engineering departments. In several instances the faculties and graduate students of these departments have shown a willingness to cooperate on studies that yield teaching results to the university and operating results to the hospital. Another source available in many communities is the methods personnel employed in local industries. An example of such use of local industrial talent on a voluntary basis is now under way in the cooperative industry-hospital program at New Brunswick, N.J.

There is no dearth of help available to the hospital administrator who really wishes to improve the methods in use in his hospital. The essential requirement is the refusal to take any method in the hospital for granted. Such an attitude throughout the organization can overcome the criticism of institutional inertia that haunts the hospital field.



Above: Architect's model of the Coney Island New General Hospital with existing building at far left. Right: Progress photograph of the hospital as it looks under construction.



THE MODERN HOSPITAL OF THE MONTH

Coney Island Hospital planners came up with an

Above-Average Solution to Below-Grade Site

JOSEPH BLUMENKRANZ
Architect-Hospital Consultant, New York City

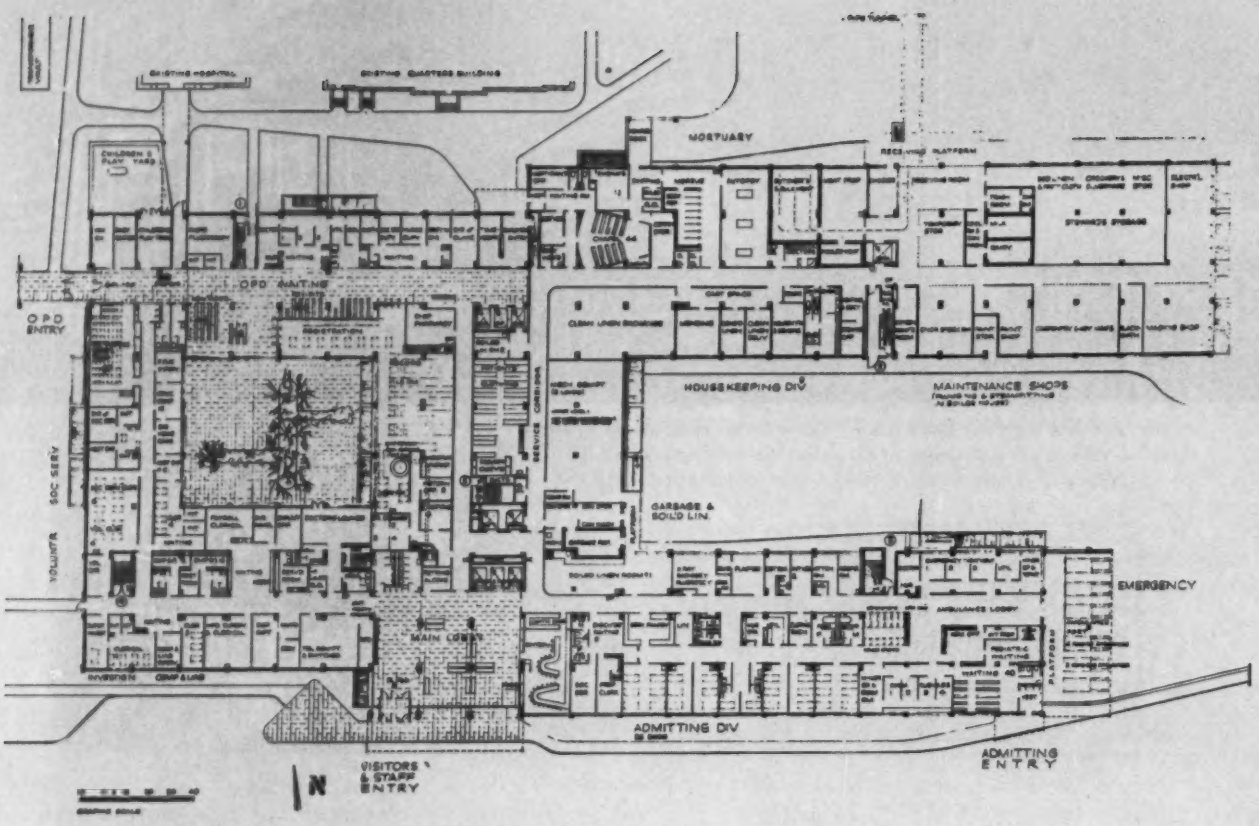
IN DESIGNING a new municipal hospital to be built by the New York City Department of Public Works, we were confronted by a flat site a few feet above sea level. These conditions prevented the use of cellar areas and contributed to a fresh approach in planning a hospital that has wide and important implications.

Generally, the basic research in a hospital concerns itself with over-all organization, improvement of planning standards in the various departments, and concern for the best possible physical environment for patients, staff and employes. In the Coney Island New General Hospital this has been true, but in addition a solution has been developed that will considerably improve maintenance and construction possibilites by all the space below the first floor slab being devoted to utility lines and mechanical equipment.

(Continued on Page 78)

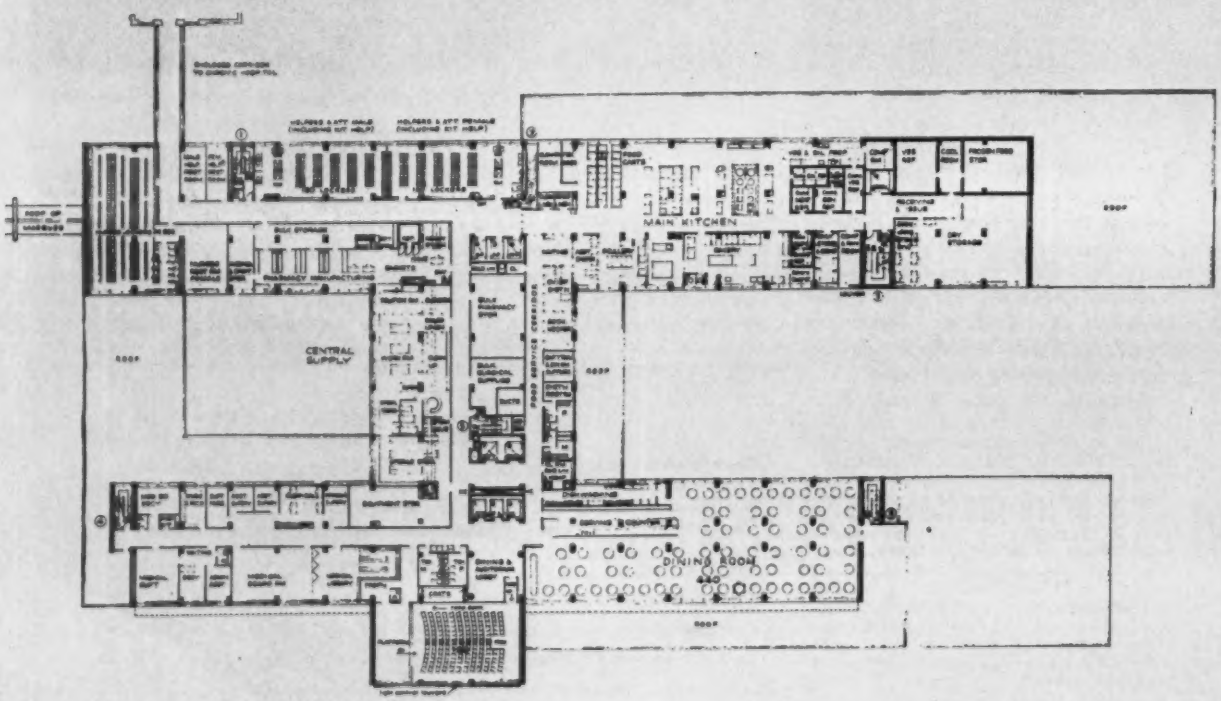
	Construction of New Buildings and Miscellaneous Structures	Alteration to Existing Hospital
General construction	$10,352,000	$424,900
Plumbing	1,384,965	167,731
Heating and ventilating	1,385,120	37,000
Electrical	1,314,343	113,015
Total	$14,409,428	$742,646
Total bed capacity		819
Cost per bed		$18,500
Cost per square foot for new construction		$ 24

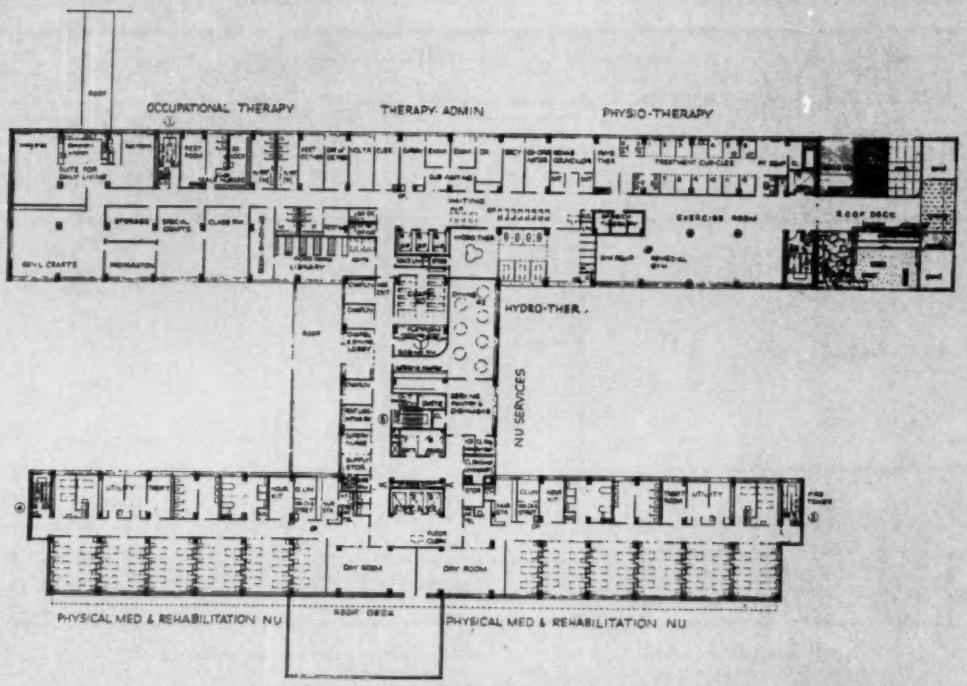
Andrew J. Thomas was architect for the project, with Katz, Waisman, Blumenkranz, Stein, Weber, associate architects. It was designed under the supervision of the department of public works, of which Frederick H. Zurmuhlen is commissioner, Albert B. Bauer, senior architect-hospitals, and Alexander Beresniakoff, architect in charge. Dr. Marcus D. Kogel was commissioner of the department of hospitals at the time. V. L. Falotico & Associates were the mechanical engineers; Farkas & Barran, the structural engineers, and Leo A. Novick, the landscape architect.



The first floor (above) is the level on which all entrances and departures take place. Separate entrances are provided for visitors, staff, outpatients, ambulatory and emergency admissions, supplies and for removal of garbage.

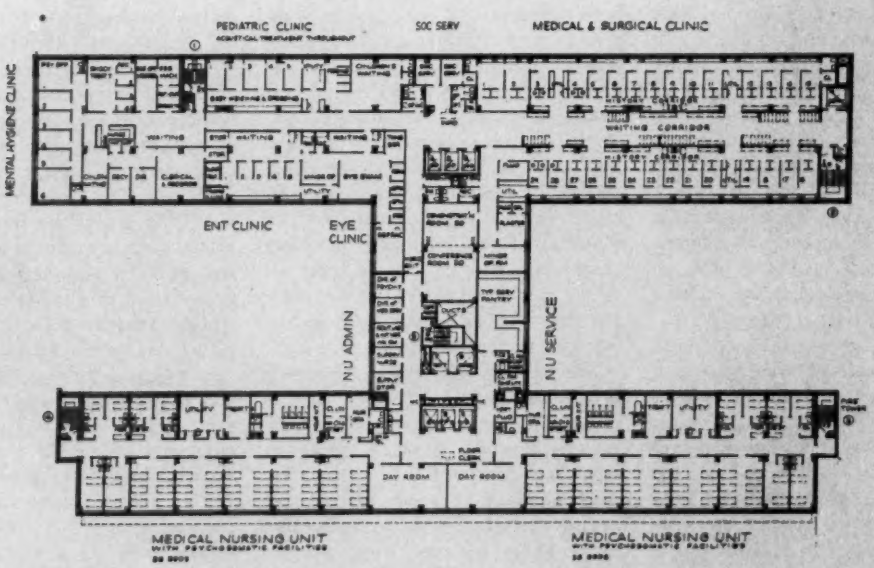
Below: The second floor is a nonpatient area. It houses the kitchen, cafeteria, central sterile supply, pharmacy, lockers and certain administrative facilities. An enclosed bridge links this floor to the existing hospital building.





Above: Plan of third floor shows relation of rehabilitation nursing units to the various therapies and to outdoor exercise spaces. Below: The fourth floor houses the general medical clinics and special outpatient clinics with the heaviest patient load. The mental hygiene clinic is related to nursing units equipped with facilities for psychosomatic treatment.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made by The Modern Hospital each month.



On the sixth floor are extraction clinics, blood bank and pathological laboratories.

The new Coney Island Hospital has 540 beds, a chassis that serves these, an additional 276 beds in the modernized existing hospital, and an outpatient department geared for an initial load of 200,000 visits a year.

The site limitations, preventing hospital uses below the entrance floor, led to a solution with three basic innovations in hospital planning.

1. In the past, cellar space has been assigned to storage and certain service facilities, such as kitchen, dining rooms, and pharmacy. In this case all these facilities have been located above grade. A nonpatient floor has been designed as the second floor, which provides light, clean, well ventilated space for the kitchen, cafeteria, central sterile supply, pharmacy, lockers and administrative facilities, as well as allowing an above-grade link, through an enclosed bridge, to the existing hospital.

2. Since a hospital has an extremely involved mechanical system, with heating risers, drainage lines and piping for the various systems throughout the building, space must be allowed for the returns of all these lines to a central mechanical core. This is generally done in a space between the first floor and the cellar, making this maze of piping difficult of access for inspection, repair or change.

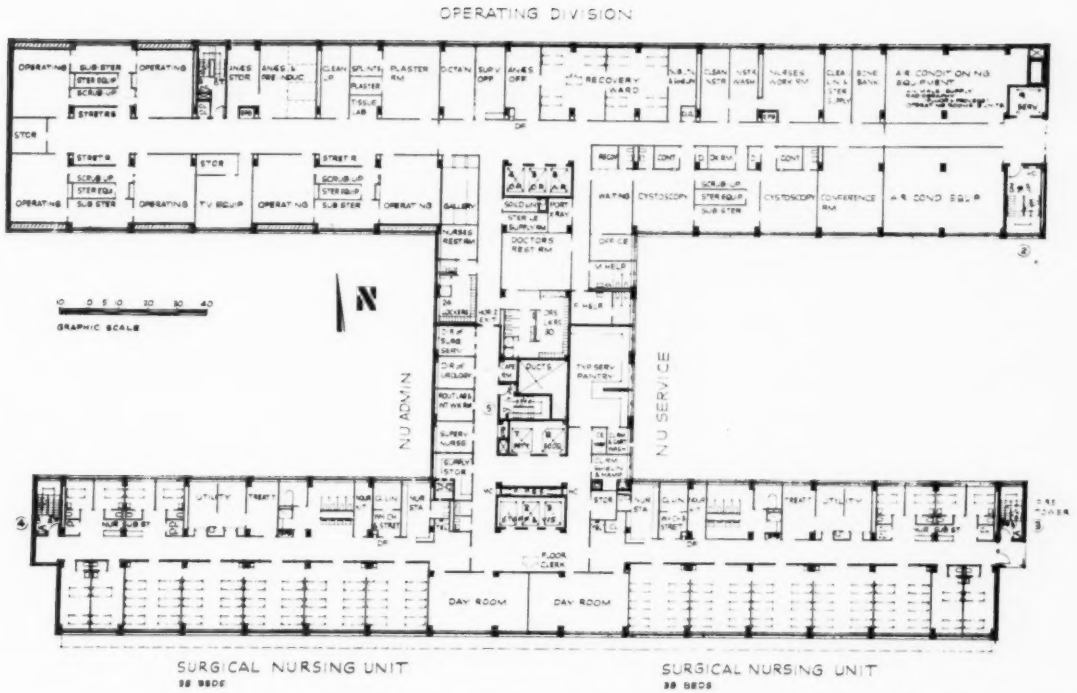
This hospital provides a complete open pipe space for all returns and service piping below the first floor. All pipes are exposed. There is adequate headroom for maintenance work but a low enough height to assure that these spaces will never be used as improvisations for hospital facilities.

3. The first floor becomes the level on which all entrances and departures take place. By a careful system of zoning, definition of circulations, and placement of elevators, it has been possible to accommodate all the circulations without interferences or the mixing of types of traffic that are unrelated. Separate entrances are provided for visitors, staff, ambulatory admitting, emergency admitting, outpatients, employes, delivery of supplies, removal of soiled linen and garbage, mortuary chapel and hearse dock, so that all these can move in and out of the building and to their proper areas in the hospital without confusion.

The basic plan locates an outpatient department and ancillary services between the new patients' wing and the existing hospital, which is being altered as a chronic disease facility. Patients' beds face south toward the ocean. At each floor a connecting link between the patients' wing and the ancillary service wing houses nursing administration and general services.

The entire hospital is an orderly and compact combination of vertical stacking and horizontal correlations. For example, the operating suite is on the same level with surgical wards; the delivery suite is adjacent to the obstetrical nursing units; the rehabilitation nursing units are next to the various therapies and to outdoor exercise spaces; medical nursing units are on the same floor with the medical outpatient service, both of which are under the same administration.

The vertical relationships in the placement of outpatient facilities will become obvious on inspection. The lowest outpatient floor has the therapies, advantage being taken of the terraces available at this level. Next above it are the general medical clinics and special outpatient clinics with the heaviest load. The mental hygiene clinic is here related to nursing units with facilities for psychosomatic medical treatment. Above this the facilities have a dual purpose, serving both inpatients and outpatients in the radiology and x-ray therapy sections. The tuberculosis clinic and a small TB nursing unit are on this floor. The floor above has a further reduced outpatient load. Extraction clinics and blood bank are related to the entire series of pathology laboratories. On the floor above, which is devoted to surgery, only the cystoscopy suite is used by outpatients.



The operating division on the seventh floor includes a cystoscopy suite used by outpatients.

Above that, the delivery suite is a completely inpatient facility.

A number of the planning features should be noted in some detail:

1. The comprehensive administrative suite, including offices for home care, is located so as to be directly accessible to both inpatients and outpatients; at the same time these are in a cul-de-sac and therefore are by-passed by extraneous traffic. Administrative personnel with which the public has no contact is on a nonpatient floor.

2. The central record room is within the outpatient registration area, yet is directly connected with upper floor nursing units by means of a continuous conveyor. It is also conveniently accessible to the admitting division.

3. Ambulatory admissions as well as ambulance cases enter through parallel corridors leading to patients' elevators; between these corridors are located the ancillary services for both patient groups. All admission traffic is fully separated from visitors' circulation.

4. Mortuary and ambulance docks are fully screened from patients' view.

5. Garbage and soiled linen disposal are remote from food and general supply delivery.

6. Rehabilitation patients have access to several ample roof decks with various exposures for outdoor recreation and exercise.

7. The organization of the obstetrical nursing unit represents a successful modification of the rooming-in principle. The nurseries are located between each pair of patients' rooms, each group accommodating 12 bassinets with the necessary nursing and treatment facilities. In this way the babies are immediately accessible to the mothers and yet the disadvantages of the rooming-in arrangement are avoided. Separate facilities are provided for premature, suspect and isolation nurseries.

8. The central sterile supply department and the pharmacy are contiguous. The means of distribution of sterile goods and drugs is via the same continuous conveyor that serves the central record room; nevertheless, all of these departments are immediately adjacent to the elevator core, and therefore are easily reached during periods of mechanical failure of the conveyor.

9. Interior structural columns are integral with pipe shafts; this permits changes in connected equipment without disturbing alterations. Structurally, the steel skeleton has uniform bays. In lieu of single girders at columns, pairs of channels are framed with a space between them; this allows for utility chases at column centers.

The exterior columns on the north and south walls are set back from the face of the building. This cantilever reduced the weight of steel framing and provided a shaft between the outside skin and the columns for heating lines, leaders and some additional utility piping. Through the use of this system window areas can be nearly continuous.

10. The concrete sunshades on the south façade are penetrated to permit the escape of air from underneath.

11. The kitchen on the second floor is designed in the width of one wing of the building. It has excellent natural light and through-ventilation, in addition to the mechanical supply and exhaust, a carefully developed production flow, and interior finishes that ensure cleanliness and low maintenance.

12. A new type of laboratory layout and furniture has been developed to allow for flexibility in assignment of spaces and flexibility in the specific use of any one laboratory. The standard manufactured under-counter cabinets have been replaced with wheeled under-counter shelf trucks which can be located as required, with adjustable shelf and storage possibilities. These allow work and knee space.

Within the framework of the city's program and standards, many innovations have been introduced to make Coney Island Hospital a significant advance from the point of view of patients, staff and employes.

Everybody Talks About Prepackaging

but Touro Infirmary survey reveals few hospitals agree on standards

PHILIP J. LANG
Assistant to the Director, Touro Infirmary, New Orleans

SAMUEL E. REDFEARN
Administrator, North Hollywood Hospital, North Hollywood, Calif.

UNTOLD millions of employe hours have been—and are being today—consumed in hospital central sterile supply departments in the monotonous and laborious preparation and wrapping of surgical dressings and supplies for sterilization. In the past, many of these hours have been those of volunteers, too many, those of student nurses. Today there is no denying that most of these tedious hours are those of paid personnel and that the hours amount to an imposing figure.

A mechanized assembly line technic at the producer's factory turning out prepackaged units suggests itself as an economy measure. This idea is not new. Prepackaging of routine surgical dressings by the manufacturers has been under consideration by hospital standardization committees at virtually all levels. Manufacturers have demonstrated their interest recently with the marketing of a prepackaged obstetrical pad.

The objective, it is submitted, is sound: An acceptable, even a more acceptable, technic at a saving to the hospital of time, employe boredom, and pay-roll expense. The problem: The notorious lack of standardization in hospitals coupled with barriers of tradition and the very human resistance to change of any sort. But what of the attitudes prevailing among hospitals today? Will hospitals approve standardizing on certain prepackaged central supply packs in order to realize this objective?

A survey was undertaken by Touro Infirmary to determine if hospital acceptance of standardized packets could be expected. A letter and questionnaire were sent to 500 hospitals having central supply departments and bed capacities of more than 200. A total of 125 answers was received, a response of 25 per cent. No follow-up was made after the original letters were posted. The questionnaire was admittedly a time consuming one to answer, and, therefore, the inclination exists to regard the 25 per cent response as indicative of fairly widespread hospital interest in the problem. No claim is made relative to the adequacy of the sample, particularly since the percentage response is subject to further reduction in the consideration of the individual items polled, because many hospitals answering the questionnaire omitted certain items on the questionnaire or indicated that they were not used.

In order to determine that the response was indicative of a cross section of the entire nation, a breakdown of responses by states showed that replies had been received from 35 states and the territory of Hawaii. The breakdown of responses by state groups follows:

State Groups	No. of Answers
New England	8
Mid and South Atlantic	43
North Central	42
South Central	14
Rocky Mountain and Pacific	17
Hawaii	1
Total	125

The questionnaire results are set forth in the table on page 81. The interpretation of the results should be undertaken item by item, particularly with respect to standardization possibilities and consumption rate. Under the columnar section entitled "Number of Items in Package," it will be noted that only in a few instances does the numerical response favor similarity with the Touro questionnaire package. Indeed in one instance, there were 22 responses and only four were the same as Touro's, while 16 others differed each from the other. This points up the wide variance in technic and procedure among hospitals of similar size. In the over-all picture, for each "Same as Touro" response there were three "Other Than Touro" replies. No significant trends to favor a particular style of packet were detected other than those being worked toward on the questionnaire.

The section entitled "How Packaged" further emphasized the difference in hospital technic. Some similarity was demonstrated in the "Paper Wrapped" category, particularly for certain packs other than vaseline or nitrofurazone coated gauze where use of metal trays predominated. Thirty-one per cent of the answers were marked "Paper Wrapped." The number of hospitals using paper bags is relatively small—10 per cent of the total responses. Grouped under "Other," the use of linen wrappers is predominant, although the heading does include metal trays, cans, drums and miscellaneous. Seemingly, a great many hospitals still use more cloth than paper to wrap C.S.R. supplies for sterilization. The introduction of prepackaging at those hospitals would effect a dual blessing.

The section entitled "Touro Packet Acceptable" is shown twice, once separately from the use factor and once with the use factor. This was necessary because many hospitals expressed an opinion as to the accepta-

(*Continued on Page* 82)

At the time this survey was made, Mr. Redfearn was associated with Touro Infirmary.

TABLE 1—RESULTS OF TOURO INFIRMARY PREPACKAGING SURVEY*

Item Number and Description	Hospitals by Size	No. of Ans.	Not Used or Not Ans.	No. of Items in Package: Same As Touro	No. of Items in Package: Other Than Touro	How Packaged: Paper Bag	How Packaged: Paper Wrapped	How Packaged: Other	Touro Packet Acceptable: Yes	Touro Packet Acceptable: No	Touro Packet Acceptable: ?	Number of Packets Used Annually — Touro Packet Acceptable? Yes: No. Hosp.	Yes	No. Hosp.	No	No. Hosp.	Undecided	No. Hosp.	Total Use
Peri Pack	200-299	37	15	4	18	6	9	8	12	9	3	8	141,390	5	115,850	3	154,080	16	411,320
1—paper towel,	300-399	39	23	4	12	6	4	8	15	10	3	13	838,357	2	44,400	..	.....	15	882,757
folded	400-499	15	10	2	3	..	3	2	5	8	1	2	55,800	2	28,200	1	8,760	5	92,760
6—cotton balls, large	500-over	34	17	2	15	3	8	3	7	18	6	5	275,140	6	1,250,742	5	96,044	16	1,621,926
1—peri pads, large	Totals	125	65	12	48	15	24	21	39	45	13	28	1,310,687	15	1,439,192	9	258,884	52	3,008,763
Perineal Pads	200-299	37	5	20	12	11	11	10	22	11	4	15	114,144	4	11,240	4	54,136	23	179,520
12 regular peri pads	300-399	39	6	16	17	13	9	6	21	9	4	16	421,892	5	9,140	4	18,990	25	450,022
	400-499	15	1	9	5	4	4	5	8	6	..	7	270,690	4	77,700	..	.....	11	348,390
	500-over	34	5	13	16	13	9	8	15	9	8	11	147,951	6	324,234	8	144,104	25	616,289
	Totals	125	17	58	50	41	33	29	66	35	16	49	954,677	19	422,314	16	217,230	84	1,594,221
Colostomy Pads	200-299	37	11	14	12	1	20	7	21	7	3	15	316,362	5	99,220	3	65,600	23	481,182
(ABD)	300-399	39	5	20	14	4	19	10	24	7	3	18	562,711	3	33,048	3	74,588	24	670,347
1—colostomy pad	400-499	15	2	10	3	..	10	3	11	2	..	9	323,065	2	282,944	..	.....	11	606,009
	500-over	34	6	17	11	3	15	9	15	8	5	12	565,139	6	652,552	3	216,225	21	1,433,916
	Totals	125	24	61	40	8	64	29	71	24	11	54	1,797,277	16	1,067,764	9	356,413	79	3,191,454
Dressing Pack "A"	200-299	37	13	10	14	..	18	6	17	9	1	12	159,176	6	76,800	1	5,000	19	240,976
3—cotton-filled	300-399	39	14	3	22	1	16	8	18	5	1	13	353,445	2	107,000	1	13,950	16	474,395
sponges 4" x 8"	400-499	15	4	2	9	1	7	3	8	2	1	7	646,750	1	210,000	1	3,285	9	860,035
folded once to	500-over	34	14	2	18	1	9	10	9	8	4	7	354,079	7	643,282	2	88,446	16	1,085,807
4" x 4"	Totals	125	45	17	63	3	50	27	52	24	7	39	1,513,450	16	1,037,082	5	110,681	60	2,661,213
Dressing Pack "B"	200-299	37	23	1	13	2	4	8	6	8	2	5	32,120	6	140,890	2	13,320	13	186,330
25—cotton-filled	300-399	39	19	2	18	1	8	11	10	10	2	4	357,000	4	71,400	1	7,000	9	435,400
sponges 4" x 8"	400-499	15	3	4	8	1	3	8	4	8	..	2	70,370	5	182,260	..	.....	7	252,630
folded once	500-over	34	13	..	21	..	5	15	5	14	3	4	73,488	5	869,014	3	908,850	12	1,851,352
	Totals	125	58	7	60	4	20	42	25	40	7	15	532,978	20	1,263,564	6	929,170	41	2,725,712

* For summary report on additional items, see Table 2, page 82.

bility of the packet without indicating an annual use, and the value of the use factor was enhanced by presenting it in positive, negative and undecided groups. The over-all picture shows that the number of "Yes" responses was greater than the "No" responses, but that it was not greater than the "No" and "Undecided" responses taken together.

The section "Number of Packets Used Annually" was designed primarily to aid the interested manufacturer to project a potential market for a prepackaged product. When the number of items in the packet reported differed from the number shown in the Touro packet, an adjustment as to the number of packets used was indicated.

For example, the Touro Infirmary cotton ball pack contains 100 large cotton balls. If Hospital A reported that its corresponding pack contains 50 large cotton balls and reported a use of 2000 packs per year, the 2000 figure was reduced by one-half for the purpose of presenting the expected annual consumption if the Touro packet were used. This assumption may not be entirely valid, particularly for those packs designed for a specific purpose for which the reduced amount might be sufficient. However, the procedure of reducing or increasing the consumption rate to agree with the Touro packet size was considered to be more accurate, more consistent, and more objective than an estimate drawn from specific uses.

While the evaluation of this section ultimately rests with manufacturers in their analysis of the survey, this comment is advanced: On the basis of clear-cut "Yes" responses in the "Touro Packet Acceptable" column, Items 2, 3, 4, 6, 10, 12, 14, 16, 17 and 18 appear to be acceptable by those hospitals using the greatest number of these items. The Touro annual usage figures appearing in the questionnaire are not included in the totals on the chart.

Does the survey show that hospitals are willing to adopt a different package and technic to gain the advantages of prepackaging? A positive conclusion is intimated by comparison of figures in the "Same as Touro" column with the "Touro Packet Acceptable—Yes" column. In almost all instances the latter figure is greater than the former. Conversely, where the "Other Than Touro" figure is large, the "Touro Packet Acceptable—No" figure is small. In all, there were 353 "Same as Touro" and 517 "Touro Packet Acceptable—Yes" answers. Because of the large number of "No" answers (478), much hinges on the swing of 261 "Undecided" responses. The fact that these hospitals are undecided might be interpreted as encouraging since they have the change under consideration. Several hospitals remarked that they were unable to give a definite reply because of present procedure. Indeed, one administrator said in his letter of transmittal that while he was marking a number of packets not acceptable, he felt that if they were available prepackaged, certain concessions would be made.

It is not necessary to recount the advantages of standardization. If this survey indicates one thing well, it is that hospitals differ greatly in their manner and method of accomplishing the same sterile supply objective. It is hoped that this survey also indicates some promise that these variances may be reconciled. If so, standardization, with the resulting prepackaging benefits to hospitals and the public, can become a reality.

TABLE 2—TOTAL CONSUMPTION BY REPORTING HOSPITALS*

Item Number and Description	Number of Packets Used Annually by Reporting Hospitals
Senn's Ties 1—large tie through the hole of which a 12" stay binding is looped	61,684
Dressings 8—3" x 3" gauze sponges	2,070,156
Dressings 100—large cotton balls	2,185,464
Vaseline Gauze 100—single strips fine mesh gauze 2" x 6½"	160,492
Eye Dressing 2—large cotton balls	295,442
Dressing 100—single strips 2" x 6½" fine mesh nitrofurazone-coated gauze	33,252
Plain Dressing 100—single strips 2" x 6½" plain fine mesh gauze	17,860
Plastic Dressing 1—12" x 12" fine mesh gauze folded 4 times	126,992
Plastic Dressing 1—12" x 12" surgical fabric folded 4 times	8,900
Breast Dressing 1—Flatfold gauze folded 8 times to 6" x 4"	149,654
Dressing Roll 5 yd. gauze 4½" wide, 8-ply, rolled	212,075
Stockinet 2", 3", 4" or 6" wide, 36" long	69,735
Lap Squares Flatfold gauze folded to 12" x 12". Edges sewed. 24" stay binding looped	1,442,600
Orthopedic Felt 1—6" x 12" x 4"	18,162

*Showing additional items reported in survey and "Total Use" as reported in right-hand column of Table 1.

Whether administrators like it or not the majority of them agree that

Nursing Accreditation Is Here to Stay

HUGO V. HULLERMAN, M.D.
Director of Hospital Services
United Hospital Fund of New York, New York City

IN ORDER to find out what administrators think about the future of the nursing school accreditation program, I wrote to all sections of the country and received some of the most interesting reading that has come my way in a long time. You, too, may be interested in reading these honest and searching responses. Comments on the three questions asked will be considered separately.

1. How far is the accreditation program going?

A lot of administrators are unhappy about accreditation. From Kansas, Missouri, Georgia, Oklahoma, the Northwest, California, Wisconsin, Arkansas and Texas, the answers were like this:

"The program will proceed as outlined by Esther Lucille Brown."

"I fear it is going all the way."

"How far is the accreditation program going? Only God knows."

"Will eventually reach every school of nursing in the country."

"I think the accreditation program will go just as far as the nursing education groups can push it and as far as the hospital people will allow this group to push such a program."

". . . the accreditation program is not interested in the hospital school and will exert every means to close out these schools and place nursing education within the institutions of higher learning."

"I fear that the accreditation program may be used to further the economic security program for the nurses and that recommendations and requirements incorporated in the program may eventually become a real problem to hospitals operating schools."

SOME FAVORABLE OPINIONS

I suspect a lot of you feel much the same about accreditation as the authors of the foregoing responses. However, we also have comments like these from Illinois, Indiana, Connecticut, Massachusetts:

"There has been little discussion among us locally, but I do believe that the feeling is favorable toward the accreditation program in general. This is a day of standards in everything, and we might as well reconcile ourselves to standards and higher standards from time to time. On the whole, I believe the standards are acceptable."

"The hospitals here are becoming more conscious of the need for national accreditation and are trying to gain it."

"The program is in keeping with the expanded program in the field of accreditation. I think [it] will go as far as is necessary to try to make first-rate schools of nursing out of all those now in existence."

"Summarizing the thinking of a group of administrators, it seemed agreed that it was a lot of work for nursing school personnel but probably a very good thing for them, an honest job of study was carried out, the conferences and reports contained very just criticisms, the inspectors made a good impression on the faculty and administration."

From the East came this response: "It is the opinion of many that the present accreditation has already gone too far, much less, where is it going from here on out. However, I do feel that if hospitals are to render service at the bedside during this difficult contemporary scene, there will have to be a redefinition of what is nursing service."

From the South this comment came: "I feel that it is going on until there will be far fewer accredited schools of nursing. The present accreditation thing is bound to have this end result for these reasons: Not many schools presently constituted can afford either to continue or strive for full accreditation. They are inevitably bound to come to this one point of decision: 'Are we to be a means of turning out nurses or are we to be an educational institution, the product of which is called a nurse?' When they arrive at that point, many will come to the conclusion that the present colleges and universities or public schools will have to take that type of student over and the schools of nursing turn out a product with fewer academic attainments."

Many of the foregoing answers represent majority opinion in their sections of the country. All of these administrators agree that nursing school accreditation is inevitable, but all do not like it; all agree that the accreditation program will go on and on, the implication being that the schools must become accredited or must cease producing graduate nurses.

Hospitals are split on accreditation. Nursing, on the other hand, is crusading. Its goals are definite: (1) Hospital schools shall eliminate all student service except as service is required

Condensed from a paper presented at the Middle Atlantic Hospital Assembly, May 1954.

for the student's education; (2) schools shall be accredited or cease to exist; (3) eventually schools must be "truly educational" and therefore must be under separate boards, separated from the service authority of the hospital; (4) nursing service must be improved, too, because nursing education cannot be good unless nursing service is good. Nurses see lots of room for improvement.

TREND TO HIGHER STANDARDS

We should be aware of the other things nurses believe in. The trend of the times is for high standards, and higher and higher education. Nurses maintain, but this has not been proved, that higher education will produce more nurses. If this is so, the limits of accreditation cannot be foreseen. On the other hand, if accreditation reduces an already short supply, public opinion will oppose accreditation. Because nurses are aware of this, they want the change to be by evolution; they want nurses to accept the idea of and learn how to use large numbers of nonnurses to help care for patients. Nurses assert that we do not need so many nurses if they are better educated and if they are properly assigned to nursing work in hospitals and to supervision of others who will give the nonnursing patient care.

Nurses know that accreditation stops the student from bartering her service for her education. Because nurses do not want accreditation blamed for higher patient costs, they prefer a federal tax for nursing education.

Administrators—trustees, too—are terribly concerned with school costs. One says: "In our case, allowing the full amount suggested by the League for all time on the floor, we run a deficit of more than $200,000 a year." Another: "We recently had a cost survey which, with a very liberal allowance for the nursing service rendered the hospital, showed the cost of our three-year course as $2700 per student to the hospital."

Another: "An independent audit indicates that the school of nursing costs the hospital about $3000 per month, or $365 per year per student. I believe this figure is conservative and that it actually costs more." Another: "Few hospitals have the funds . . . to maintain adequate programs of health, guidance, recreation and the many other facets which constitute good educational programs; . . . there is no gainsaying that it is costly for individual hospitals to provide nursing schools if they are to offer a truly educational program as outlined by accepted educational criteria."

Finally, in answering the question "How far is accreditation going?" we must recognize that we are living through a redefinition of what the profession of nursing is. The nurses themselves are not sure about this, nor are they sure that there will be public acceptance of what they would like to say is the hard core of professional nursing. It will take time to decide this.

We should recognize, now, that accreditation is permanently with us, that professional and practical nurses and nursing technicians, *i.e.* all those who go through a more or less formalized course of education, will expect sooner or later to obtain that education in accredited schools.

2. Can hospitals maintain control?

Some administrators replied that they think the program is ours; for example: "Hospitals can maintain control because the joint program cannot exist without the full approval of the representatives of the American Hospital Association. I believe it was pretty well brought out at the long discussions at San Francisco that this joint program finally adopted by the League was by pressure from the hospital association. They convinced the League that unless it provided a program entirely different from the previous structure, where we only had one representative, we could not go along. We also convinced the League that unless it accepted our suggestions, the end result would be that the hospital association would have to set up its own accreditation program."

Some think we are overmatched: "If you mean 'gain' control of the accreditation program and its policies, I will have to give a flat 'No.' The National League and its career staff devote their whole time and thinking to this matter, whereas hospital administrators and boards are able to give it only 'a lick and a promise'; . . . when the hospital representatives sit around the board with National League personnel we suffer from this handicap. . . . We are in this game of accreditation only with the sufferance of the National League for Nursing. They can just as easily, this year or next, abolish the present arrangement as it was equally easy for them to cut us in."

Many desire to cooperate and guide: "I believe that the hospitals can maintain control, but to do so they have to evidence a much more active interest in the program. It will not be just a lot of sitting back and criticizing everything the nursing groups do, but it will mean taking an active part in helping these people plan what is best for all concerned. . . . Joint conferences with them are attempting to educate them to the hospitals' problems. . . . I am sure that with the proper people from the organizations concerned who can sit down together and discuss what is best for the patient, the nurse, and the hospital, our ultimate goal will be reached." I think many of you believe that this is a sound approach and attitude.

From the Midwest comes this point of view: "I believe that hospitals can maintain adequate control under the present setup. It is true that in the beginning when they just sat back and criticized, the hospitals did lose control."

From the East we hear this: "If this question means 'Should the hospitals maintain full control of the program?' my answer is 'No' because they never did have full control, and they should not, any more than they should have control of a general accreditation program. It seems that the makeup of the new Executive Committee on Accreditation Policies will ensure sufficient control to keep it in balance and not let special interests dominate it. . . . As long as the interest of the patient is not lost sight of, I am not too concerned about diminishing the hospitals' 'control' of the program. . . . It seems to me that the old ideas of the hospital being an absolute law unto itself is one that should be put in File 13 and forgotten about."

FEAR POWER OF N.L.N.

Others fear N.L.N. power: "Personally, I am afraid that any organization with the power which this one will be able to amass over a period of years will be difficult to handle. . . . I do not think that hospitals can maintain control under the present setup."

Again: "It is very questionable that hospitals can maintain control of this program. . . . It is probable . . . in the end, the nursing representation would outnumber the hospital representation and maintain control; . . .

in our states the boards of nursing education are beginning to become more autocratic . . . and we have considered the possibility of appealing to the proper court."

But also from New England, Georgia, the Southwest, and the West: "I doubt it. It is a nursing function sponsored by nursing groups and I think in the end they will maintain control," and "I believe the hospitals have no control over accreditation at this time."

Our sample of countrywide thinking on this second question boils down to something like this: An occcasional administrator thinks hospitals can control the accreditation program, but the vast majority believes that hospitals never had control, do not control it now, and will not in the future. A smaller number believes that hospitals should not control accreditation but should exert a strong influence upon it, and that much they can do.

Several methods were suggested such as American Hospital Association representatives on the Executive Committee on Accreditation Policies—this we now have; financing of the accreditation program—this nurses will not accept; cooperation between A.H.A. administrators and nurses in state organizations—certainly very important; retention of individual school control by hospitals' boards of trustees and changing state laws, if necessary, to protect the hospitals from unfair and restrictive control by standardizing agencies.

CAN'T IGNORE NURSES' VIEWS

Of course, what the nurses think about this cannot be ignored. For one thing, they won't let us, and, second, accreditation belongs to their organization, *i.e.* the National League for Nursing. The nurses make no bones about their point of view, which is that accreditation is the proper function of each profession and a profession should not be dictated to in this matter. Personally, I think it is a tribute to hospitals and nurses to have worked out as they did the appointment of administrators to the League's Executive Committee on Accreditation Policies. You should send your complaints, your compliments, your ideas to Dr. Letourneau, so that this committee can know what is happening to you. It can influence the program out of proportion to what many of you may believe.

The fact remains, however, that the accreditation program is not controlled by the hospitals now, nor is it likely to be controlled by them as long as accreditation remains in the League, but it is equally a fact that at the present time the accreditation program is substantially influenced by administrators' opinions.

I think we are in a chaotic period in which we must test out many suggestions for nursing education; that it will be more and more difficult to enforce a system in which student education is secondary to student service. What we can do is to concentrate on increasing the enrollments in our hospital schools and in our college schools; insist that nurse educators make it easy for hospital graduates to go on to a degree without appreciable loss of time; prepare thousands upon thousands of practical nurses and well trained aides, and increase the use of volunteers—all of this to be supported by the strongest possible effort in *each* hospital to get these people to work closely together at the patient level. *Treasure your aides and your practical nurses!*

STAND BY THREE-YEAR SCHOOLS

We must stand by our three-year hospital schools, costly as they are, until there are convincing demonstrations that other methods will produce enough nurses. If accreditation shows signs of being more than hospitals can support, if schools close, if total national nursing enrollments are insufficient, if regional or local enrollments suffer severely, then I think the American Hospital Association should and can slow down the accreditation requirements as much as is necessary to keep our hospitals producing the number of nurses we need, and state associations can and should go to such lengths as are necessary to obtain reasonable licensing standards. If you keep your committee informed, it should be able to achieve many of the ends you desire by cooperation rather than force.

At the same time, and most important, we must accept the fact that there will be a growing number of professional nurses who will have a different education than in the past and that our nursing service in hospitals inevitably will evolve so as to remove from this group some of the duties formerly done by professional nurses. This means an ever greater use of nonprofessional personnel, and the assignment to them of greater responsibilities than they now carry. I think we should concentrate on this.

3. Has the American Hospital Association's nursing committee represented the thinking of the majority of the membership on this subject?

Several of the answers were: "I don't know."

This comment has a great deal of meaning: "I don't think the American Hospital Association's committee has been potent enough to represent or misrepresent the majority of the membership on this subject. Very few people ever hear of it or hear what it does. I believe the members just meet and concur with what the League has to offer and nothing else. They have not been very effective."

A few believed that the committee represented the majority of the membership.

An excellent observation was: "The committee has represented the thinking of the majority, and if it has in any way fallen short it has been in representing the thinking and program that can be carried on in large schools, overlooking the smaller hospitals serving a community in which most of the nurses are graduates of that school."

And the last quote really states the problem: "Now, boy, that really is the $64 question! It is hard to say what the thinking on this matter of the majority of the membership is. Honestly, with all due respect to the membership, there is a lot of mixed-up thinking, indecision, lack of knowledge, and just plain confusion. . . . The committee members are in a position of being swayed by whoever at the moment brings some powerful positive thinking. . . . They are caught in the position of having the National League for Nursing's program presented concisely, forthrightly (supposedly so) and consistently in any publication without having a counter program to represent the thinking of the membership."

This commentator goes on to say that administrators of hospitals that do not have schools of nursing are bothering themselves with accreditation or any other educational standards only to the extent that they want to know where they can get additional nurses; that administrators with large schools, administrators of government and Veterans Administration hospitals, and

administrators of privately owned hospitals all have different points of view on accreditation, so that it would be difficult to have a so-called majority thinking of the membership on this subject.

I know I have not answered the question as to where accreditation is going. I don't know and cannot say. But if we are not to steer an aimless course we must make a commitment, and I shall tell you what mine is.

1. I believe that enough hospitals and nurses and high school students and patients want the education of nurses upgraded, so that within 10 years, perhaps less, all nursing schools will be accredited. However, I am not at all sure this will be by the League.

2. Ways of financing will be found, without an unjust charge to patients and without governmental regimentation.

3. We shall see some new patterns of nursing and para-nursing education and service that will help solve the problem of numbers.

On such a basis, and recognizing that the A.H.A. is on record as favoring the objectives of accreditation, I think hospitals must act as a governor to keep the pace within reason, but not as an anchor to stop the movement completely. I think through our efforts nurses can be made to see the sense of this, and that, in the face of our many worries about personnel, it is truly remarkable that hospitals and nursing have the excellent cooperative relationships that do exist.

I should like to put in my own comment about the nursing committee. I have seen the toughest kind of thinkers put on this committee and the end result is much the same—they have to give credit to the intents of the nursing leaders even though details are annoying—and it has been almost impossible to pin down any evidence that nursing is against the three-year schools. But you must keep your committee advised of things that occur (not just opinions) if it is to be wholly effective.

In summary, this appraisal of nursing school accreditation indicates that administrators should take a positive and very strong interest in:

1. Continuing their diploma schools and having them fully accredited as soon as possible. Despite the expense of schools to hospitals, the hospital schools remain the principal and essential source of graduate nurses.

2. Developing their own side programs, using the exceedingly helpful aide training assistance now available through the American Hospital Association.

3. Increasing the use of practical nurses. In many instances, hospitals themselves might begin practical nurse schools.

4. Establishing an effective working relationship with nurses and doctors in the state and communities through such devices as joint commissions for the improvement of care of the patient. The accreditation program should be helpfully influenced by informed opinion of hospital administrators and not formulated within nursing circles exclusively.

5. Being liberal in promoting graduates of diploma schools to good positions in hospitals; avoid the pressure to appoint nurses to the better positions simply because they have degrees. The inability of diploma graduates to obtain good positions seems the most serious threat to the hospital schools, in the long run.

6. Giving all possible recognition and reasonable responsibility to the aides and practical nurses.

7. Considering how the increasing costs of nursing education in diploma schools is to be financed without unrealistic charges to patients.

Today's Nursing: Good or Bad?

CHICAGO.—In the good old days every nurse was an angel. In the bright new days of movies and TV, the nurse is every inch an angel still. But in the hospital of 1954 nurses are angels several times removed. It may be that their chief identification with angels is that they are not human.

The foregoing sums up the patient's point of view in regard to nursing care in the opinions of four experts, who otherwise disagreed as often as they agreed on nursing service as they faced an afternoon audience made up of members of the Chicago Council on Community Nursing.

"The public may think nurses should be more angelic," maintained Ray E. Brown, superintendent of the University of Chicago Clinics, a panel member, "but today's nursing is not poor nursing, it is good nursing. The time the nurse spends with the patient is more productive than the longer periods she could spend at the bedside some years ago."

Refuting this optimism came Edith Payne, director of nursing at St. Luke's Hospital, Chicago. "Patients lack the nursing care they need," Miss Payne held. "Hospitals can't seem to afford to supply enough nursing personnel to give patients the care that nurses think is good. If you are satisfied to have merely supportive care, you aren't getting what nurses call good nursing. It may not even be safe nursing."

It's not good nursing from the point of view of the typical patient at Michael Reese Hospital, Chicago, judging from a recent survey. "The nursing service was competent and technically skilled but not friendly. The nurses treated me like a case, not a person," was the most frequent reaction of patients, as reported by Lawrence H. Selz, head of a public relations firm and a board member of Michael Reese.

The value of an advisory committee in the improvement of nursing care was conceded by all members of the panel. Dr. Herman F. Meyer, on the staff of Children's Memorial Hospital, Chicago, declared that in his opinion the greatest single factor in poor nursing care is the failure of the superintendent of nurses, the hospital administrator, and the physician to understand each other's point of view.

All the experts conceded that hospitals have not done a good job of interpreting to patients what nursing is supposed to do. A nursing advisory committee, they held, could assist in this task, becoming the ears or listening post of nursing service itself.

Dr. Meyer declared, and the others concurred, that the best line of communication between patient and the hospital is the doctor. The observations a patient makes to his physician can be carried to the director of nurses if, after evaluation, he thinks them valid criticisms. Another large factor in interpretation is the volunteer or auxiliary group. A member of the audience suggested that the Visiting Nurse Association is in an enviable position to learn patients' views on hospital service.

It cost $8 and a few hours' time to make this

Cassette Changer for Angiography

JOHN A. ROOT, M.D., and RUSSELL G. WILLIAMSON, M.D.

Respectively, Intern and Resident in Surgery
Maine General Hospital, Portland, Me.

THE increasing interest in vascular surgery has given angiography a new position of importance. Angiography is a technic by which radiopaque dyes are injected into blood vessels to outline their course and their branches. It is helpful in these studies to be able to produce a series of x-ray exposures of an extremity in fairly rapid succession. The filling of vessels can thus be followed for example from the thigh to the ankle by using only a single injection of radiopaque dye.

Wehrmacker and Stocker* have described in a U.S. Army manual a cassette changer that utilized a welded metal frame. We devised, on a plan similar to that article, a simplified, economical wooden cassette changer. The total cost of this device was approximately $8 and we constructed it in a few hours.

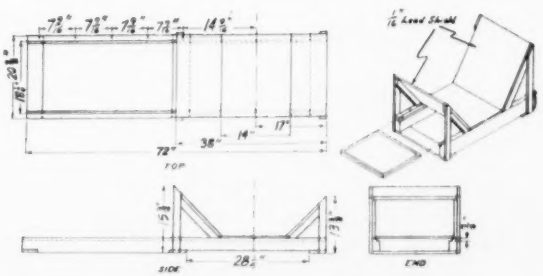
The sides of the frame are 2 by 4's notched on the underside to fit the x-ray table and grooved for their entire length on the upperside to hold and guide four cassettes. The crosspieces of the frame, as well as the uprights and shielded wings, are made from ¾ inch boards. The platform upon which the patient's extremities rest is a ⅜ inch plywood board, which is fastened with wood screws from the bottom surface up into the lower edge of the shielded wings to prevent their sagging under the weight of the patient. A 14 by 17 inch Lysholm grid is placed on this platform. If only a half-cassette width is needed for each exposure a 7 by 17 inch lead impregnated rubber sheet can be placed over the grid to shield the other half of the cassette.

Two 4 inch sponge rubber mattresses, placed on either side of the cassette changer, provide the patient with comfort heretofore unsurpassed during a roentgenologic examination.

Two persons are able to handle all details of producing an angiogram. After the surgeon has injected the radiopaque dye, the operator activates the x-ray tube with a switch held in one hand. He then pushes the hindmost cassette to the next station mark at 7-9/16 inches, if half-cassette widths are being used, or to the second station mark at 15⅛ inches, if whole cassette widths are being used. He again activates the x-ray tube and so on until the desired number of exposures have been made.

As many as four exposures can be made in three seconds, although this speed usually is not necessary in angiography. The exposed cassettes are allowed to drop on a table on the opposite side, which is slightly below the level of the cassette changer.

This simple cassette changer is effective and readily available to any hospital at a nominal cost.



Right: Detail drawing of the wooden cassette changer. Below: If only a half-cassette width is needed, a lead impregnated rubber sheet can be placed over the grid as a shield for the other half.

*Wehrmacker, W. H., and Stocker, G. F., Cassette Changer for Angiography and Angiocardiography. U.S. Armed Forces M. J. 4:1638, 1953.

About People

Administrators


Dr. A. J. J. Rourke

Dr. Anthony J. J. Rourke has resigned as executive director of the Hospital Council of Greater New York. Dr. Rourke, who has done consulting work for a number of years, will spend his entire time as a consultant in hospital administration. Prior to accepting the New York post, Dr. Rourke was physician superintendent of Stanford University Hospitals for 13 years and a lecturer in hospital administration at the University of California. Dr. Rourke is a graduate of the University of Michigan Medical School, of the Bentley School of Accounting and Finance and of Suffolk Law School, both in Boston. A past president of the American Hospital Association, he is also a fellow of the American College of Hospital Administrators, the American Medical Association and the American Public Health Association.

Robert D. Southwick, administrator at Concord Hospital, Concord, N.H., has been appointed administrator of the new Lower Bucks County Hospital, Bristol, Pa., which will open this fall.

June C. Roberts and **Katherine Bogarts,** both from Sacred Heart Hospital, Spokane, Wash., have been named administrators of Garfield County Memorial Hospital, Pomeroy, Wash., succeeding **Irene Ciminera** and **Marian Gundlach,** who have resigned.

Harry M. Weir, administrator of Everglades Memorial Hospital, Pahokee, Fla., has been appointed consultant-administrator of Seminole Memorial Hospital, Sanford, Fla. He is succeeded by **Jesse W. Reel,** former administrator of Raiford Memorial Hospital, Franklin, Va. Mr. Reel has recently received his master's degree in hospital administration from the Medical College of Virginia.

Everett A. Johnson, superintendent of Chicago Memorial Hospital, Chicago, has been named superintendent of Methodist Hospital, Gary, Ind. He succeeds **George F. Wren,** now director of Aultman Hospital, Canton, Ohio.

Orval H. Guenther, who has been employed by Milwaukee County, Wisconsin, since 1935, has been appointed deputy director of Milwaukee County Institutions and Departments. Mr. Guenther is a graduate of Marquette University School of Business Administration and is a certified public accountant. He is a member of the Wisconsin Hospital Association and of the Wisconsin Society of Certified Public Accountants.

George M. Percival, retired United States Army colonel, is now administrator of the Clark County Hospital, Winchester, Ky.

Dr. William L. Glover, staff physician at Columbus State Hospital, Columbus, Ohio, has been named superintendent of Cleveland State Hospital, Cleveland, succeeding **Dr. Harold A. Budd,** who has resigned.


Norman D. Bailey

Norman D. Bailey, general manager of the House of St. Giles the Cripple in Brooklyn and Garden City, N.Y., has accepted the position of executive director at Grant Hospital, Chicago. Mr. Bailey was formerly associate director of Michael Reese Hospital in Chicago. He is a lecturer in hospital personnel administration on the faculty of the program in hospital administration at Northwestern University.


G. B. Rosenfeld

G. B. Rosenfeld has been appointed administrative resident at Jewish Hospital Association, Cincinnati. He will serve a one-year residency at the hospital to complete work for his master's degree in hospital administration from the University of Toronto.

Dr. Donald J. Caseley, who has been medical director of St. Luke's Hospital, Chicago, is now medical director of the University of Illinois Research and Education Hospitals and associate dean of the University College of Medicine.

John M. Nichols, assistant manager of Veterans Administration Hospital, Lyons, N.J., has become manager of the V.A. center at Bath, N.Y.

Ray Clark, who has received his master's degree in hospital administration upon the completion of his residency at Robert Packer Hospital, Sayre, Pa., has been appointed administrative assistant there.

Rex von Krohn, administrator of St. Joseph-Benton Harbor Memorial Hospital, St. Joseph, Mich., has become administrator of St. Josephine General Hospital, Grants Pass, Ore.

Frederic R. Veeder, administrator at West Nebraska Methodist Hospital, Scottsbluff, Neb., has been appointed administrator of Children's Hospital at the University of Louisville School of Medicine, Louisville, Ky. **Max Coppom,** head of the accounting department at West Nebraska Methodist Hospital, is now administrator.

Earl C. Mechtensimer, recent graduate from Northwestern University's program in hospital administration, has completed his administrative residency at Highland Park Hospital, Highland Park, Ill., and has been appointed hospital consultant for the Illinois State Department of Public Health.

Elmer Mosee, administrator of People's Hospital, St. Louis, for the last 10 years, has been discharged by the board of trustees. The Social Planning Agency of St. Louis is investigating the situation. Mr. Mosee has been succeeded by **William Andrews,** a graduate of Washington University-Barnes Hospital program in hospital administration, who has just completed his year's residency at De Paul Hospital, St. Louis. Mr. Mosee was responsible for obtaining federal financial aid and necessary priorities during World War II which made the present hospital building possible.

(*Continued on Page* 174)

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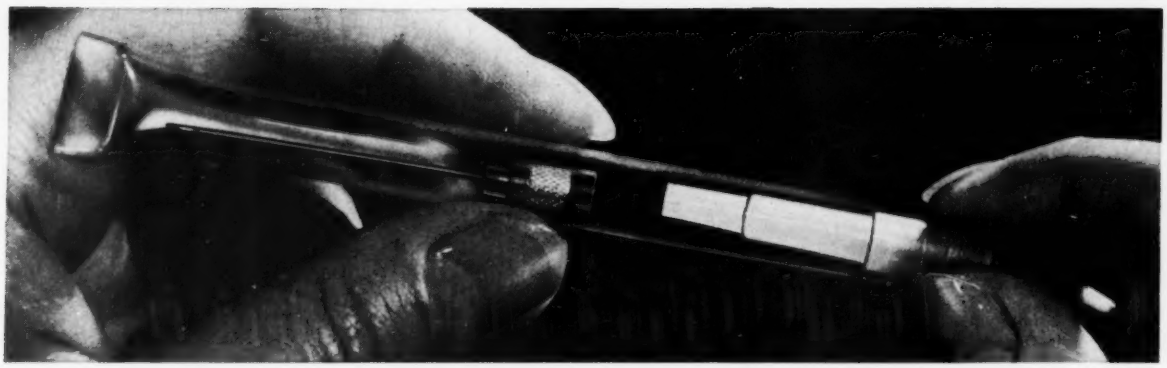

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Volunteer Forum

Conducted by Raymond P. Sloan

The Medical Staff IS the Governing Board

—and here's why the administrator likes it that way

EVELYN CRAIG, R.N.
Superintendent, Watsonville Community Hospital
Watsonville, Calif.

FOR the last seven years I have been superintendent of a 75 bed, nonprofit community hospital which serves a population of 33,000. I have been employed by the hospital for 13 years. During this entire time the board of directors has been made up of no less than 20 M.D.'s, all of whom practice in the community. Three years ago the only layman ever to serve, a banker, was elected. Our by-laws provide that the same number of doctors will always be on the board, but in future more laymen will be added. The younger men who have been accepted on our staff are encouraged to attend the directors' meetings and to become familiar with the problems of the hospital.

Hospital administrators whom I meet seem rather shocked and sympathetic at this state of affairs. I like the arrangement, and will try to show you how it has worked here. A little history will give a better picture of how we operate.

The hospital was built in 1938 by the doctors of the community who were eager to have a modern and adequately equipped hospital. At that time the only hospital in town was owned by a doctor who was getting ready to retire. His hospital building was quite a few years old and not up to the community needs. This enthusiastic group of doctors invested their own money and sold stock to people of the town who liked the idea of a new hospital. Fund raising then, as now, was not an easy task. The people who invested considered it more or less a donation and were not at all assured that they would ever see their money again. However, the hospital with its medical board of trustees paid all investors 4 per cent interest from 1938 to 1951. In 1951 it was decided to convert to a nonprofit organization. The stocks were called in, and interest bearing debentures issued to the stockholders. Thus, every investor will receive his original investment plus 4 per cent interest until the debentures are retired, and the hospital becomes self-owned.

I feel that our medical governing board has made a success of this hospital both financially and otherwise. I compare our costs every month with a cost survey in which our figures are included. Our costs are always lower, sometimes as much as $4 per patient day less than those of hospitals in our classification on the Pacific Coast. We have a good reputation in our town and are drawing patients from fringe areas and adjoining towns.

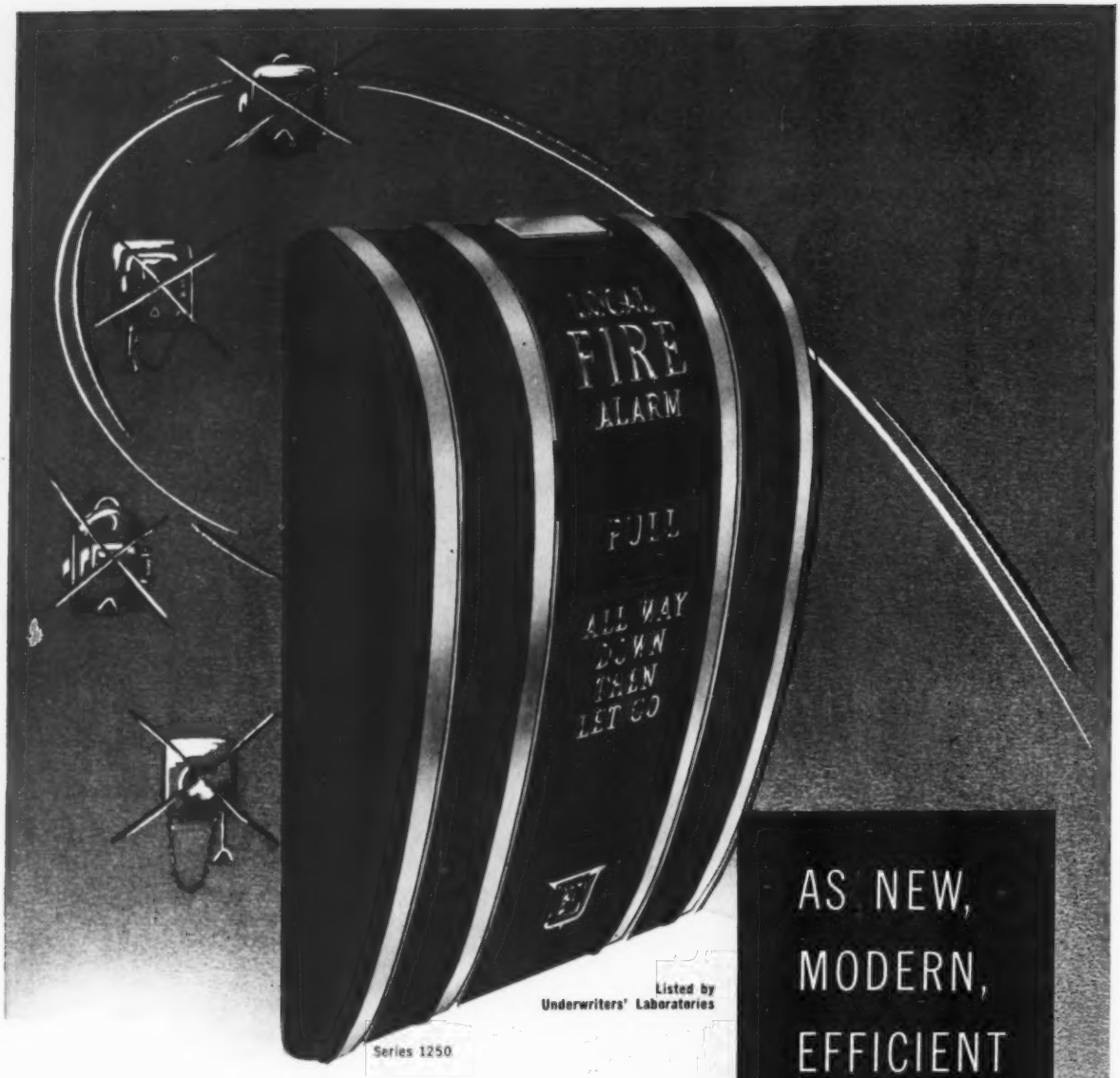
The executive committee, consisting of the officers and senior members of the board, takes the lead in hospital affairs. Every member of the medical staff has, as a director, the privilege of being present to air his grievances or make his requests heard. Each has a vote on any matter brought up. Knowing of this opportunity to blow off steam has a soothing effect. After the directors' meeting, the doctors figuratively "change their hats" and have their monthly staff meeting.

Our record department has been set up to meet standards for accreditation. Only in the last four years has this been the case. During that time the doctors have realized the value to themselves, and to their offices, of having complete records. The medical staff polices this department. We occasionally post a list of incomplete charts. Staff discipline is maintained by the doctors themselves—and it works.

It has been said that doctors aren't businessmen. Actually, I don't think that is too important. Our board retains a certified public accountant, who makes a monthly audit of the business, other than medicine, and submits a monthly report. A local attorney takes care of any legal problems. We can get any special advice we need.

The principal business of any hospital is to care for the sick and to provide the best facilities for this purpose. This hospital is the doctors' workshop, and they naturally take pride in the quality of the work turned out. The doctor is interested in the maintenance of the shop and its equipment because he needs it in his work. I feel certain that every one of our

(*Continued on Page* 93)



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doctors would resent having a lay person tell him how to take care of his patients, after he has spent the best years of his life learning how to do it himself.

It has been helpful having doctors as directors for many reasons. They come to the hospital every day and can take the hospital's pulse as well as that of their patients. There have been times when business hasn't been too good. During these times, our directors are concerned because they know that the hospital has to operate in the black if they are to have a place to care for their patients. When the census is low, our doctors let their patients stay a day or so longer, if they wish. If we're overcrowded, they let the ones who are able go home. Thus we stabilize our census.

By being directors, the doctors have become economy minded, and we have accomplished standardization of supplies and drugs. When new equipment is requested, we have an unwritten law that it must be useful to all. Any doctor using special instruments or equipment provides his own. All of these things have been factors in cutting our costs. The hospital policies are made by the doctors, thus simplifying the task of carrying them out. The mutual responsibility of running a hospital is a strengthening bond. The doctors of this community practice together harmoniously, and there is a friendly attitude among them.

The shifting around of hospital administrators has been noted in hospital literature. In the hospital conference of which this hospital is a member (22 hospitals), during the seven years I have been attending meetings, there are only three of the original administrators remaining on the job. One of these is having serious trouble with her all-lay board, in which altercation the medical staff is supporting her. The 19 hospitals that have made changes have had from one to three changes of administrator in seven years. It has occurred to me that dissension between the board of directors and the medical staff may be an important factor in this costly shifting of administrators.

I like having a medical governing board. We speak the same language. Naturally, we have our ups and downs just as does any group of human beings, but so far we have always ended by being friends. I appreciate their guidance in caring for their patients.

Conducted by Robert F. Brown, M.D.

Columbus Plan Begins to Roll

Action against fee-splitting is proving as effective in other communities as it did in Columbus

GREER WILLIAMS
Director of Public Relations
American College of Surgeons, Chicago

THOSE who in darker moments wonder if honesty is, indeed, the best policy may take heart in news from the fee-splitting front. In Iowa, where the state medical society had endorsed a form of fee-splitting between referring physicians and surgeons which the American Medical Association had held to be unethical, officials of the American College of Surgeons and a group of Iowa surgeons opposed to fee-splitting of any kind recently agreed to a plan of action which will protect the ethical reputation of the college's 220 fellows in Iowa. This plan, subsequently adopted by the A.C.S. board of regents, requires that all Iowa F.A.C.S.'s submit to financial audits to prove they do not split fees or resign, under threat of expulsion if they do neither.

Those who, on the other hand, wonder why common sense and ultimate realism cannot prevail in the way the surgeon and his assistant handle the patient's fee may find some cause for happiness in the subsequent action of the American Medical Association's house of delegates in adopting a Judicial Council report which declared a combined itemized bill is ethical in presentation of insurance claims or where the patient specifically requests it. In brief, the A.M.A. now holds it to be ethical for the surgeon and referring physician (who may or may not be the surgical assistant) to submit a joint bill itemizing the charges of each as long as payments by the patients are separate. Itemization is standard American business practice, and the A.C.S. itself recognized the acceptability of joint itemized bills in insurance claims as early as 1952.

These two actions, the A.M.A.'s to define fee-splitting and the A.C.S.'s to enforce the ethical injunction against it, provide an adequate occasion for pause to review the spread of the Columbus Plan since its introduction in the Ohio capital by the Columbus Surgical Society on Jan. 1, 1946. The Columbus Plan, according to informed opinion, has been successful in controlling fee-splitting. Taking its basic strength from the unanimity, or we're-all-in-it-together principle, the society began with nearly 100 per cent participation by all operating surgeons in Columbus. A few holdouts were later persuaded to go along.

The plan, originated by fellows of the college who decided it was high time to clean house, said in effect, "If you do not agree to having a certified public accountant, hired for this purpose, look into your account books, patient lists and income tax return every year to see whether you are splitting fees, Doctor, we shall be forced to go after your hospital staff privileges and, if we have to, invite attention of the internal revenue agent to your income."

Noting that fee-splitting already was illegal in Ohio and hence against public policy, the Columbus society endeavored to make certain that the internal revenue service would disallow splits as a deduction from taxable income by informing the agent in charge that fee-splitting was no longer generally practiced in the community and thus could not be regarded by internal revenue investigators as a customary or necessary expense of doing surgery, as it apparently had been, despite the law against it. While there were ways of evading the C.P.A.'s detection of fee-splitting, such as double bookkeeping and alternate billing of patients by referring physician and surgeon, these seemed to involve risk of criminal evasion of income tax. Thus, the approach had sharp teeth, borrowed from Uncle Sam. The psychological impact was forceful, and fee-splitting in Columbus stopped overnight.

For a long time afterward, however, many of the best people in medicine viewed the Columbus Plan in a mood just a fraction short of horror. Observers, including leaders of surgery who abhorred fee-splitting as a work of the devil and sought an end to it via exhortation and the signing of pledges, examined the plan at arm's length, between index finger and thumb. They deplored its odor of coercion and its apparent invasion of individual privacy. Some mentioned that doctors are supposed to be honest, and should not have to be compelled. Every F. A. C. S. takes a gentleman's oath that he won't split fees, and so does every staff appointee in an accredited hospital. Still, over the last half century, it is known that a great many "honest doctors" have split fees. An explanation was provided by a Columbus surgeon and leader of the reform: "Sure, all of us take a gentleman's oath; but who said all of us are gentlemen?"

This article also appears in the Bulletin of the A.C.S., July-August 1954.

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Then, too, the possibility that a human being can be honest in one way and not in another, or in most ways but not in all, had been overlooked.

The very effectiveness of the Columbus Plan posed a dilemma. Which is worse, the evil and its toleration, or the prevention of the evil by direct interference with the individual's right to be unethical? Which is better, a hypocritical signing of a pledge not to split fees or the signing of an agreement to prove you don't split fees?

Officials of the American College of Surgeons themselves were content quietly to contemplate the Columbus Plan and see how it turned out. A follow-up, in 1952, indicated that Columbus indeed had had a five-year cure. Still, it seemed to have been something of a freak, not likely often to recur.

A.C.S. APPROVAL WITHDRAWN

When in 1951 complaints reached the college that some members of two hospital staffs in Bloomington, Ill., were engaged in unethical practices, the hospitals were surveyed and removed from the approved list. Asking the college what they could do to get back on, the hospitals were informed that, among other things, such as completing records and enforcing staff rules, they could furnish evidence their staffs were not splitting fees. By action of the governing boards, each of three Bloomington hospitals presently imposed the requirement that an applicant for staff appointment or reappointment must submit a certificate from an auditor attesting that he had examined the doctor's patient accounts and found no evidence of fee-splitting. Later, the hospitals made such certification an annual requirement. Here, as in Columbus, all information indicated that fee-splitting is a habit as easy to break as that of smoking—all you have to do is stop.

Some wondered if Bloomington wasn't a freak, too. It was certainly true that even where fee-splitting had become so ingrained that doctors couldn't see anything wrong with it, and there were such things as "honest fee-splitters," meaning surgeons who admitted they split fees, the practice could be stamped out. On the other hand, enforcement of the Columbus Plan seemed to require a special set of forcing circumstances in each case.

This view reckoned without a proper understanding of two forces, however. One has been the determination of leaders of the college, such as Drs. Evarts A. Graham, Paul R. Hawley, Loyal Davis, and I. S. Ravdin, plus other regents and fellows, to speak the truth, as they knew it had not been spoken. As the college's large mailbag has revealed, manifestations of courage stimulate others to take heart.

Second is the force of public opinion. As the college's director and its regents stuck their necks out, speaking boldly in disregard of the silence which has traditionally cloaked fee-splitting and unjustified surgery, they were required to duck an occasional verbal tomato or dead cat, objects not infrequently thrown by an F.A.C.S. but almost invariably originating from within the medical profession. While these critics accused the college leaders of washing dirty linen in public and destroying public confidence in the medical profession, expressions of public admiration poured in, plainly revealing a different reaction—that the college had provided cause for renewed public confidence in the honesty of doctors. Gradually, many critics have either changed their minds, or have sought a firmer hold on their tongues, with even those who favor fee-splitting joining in public denunciations of medical sins. It is much too early to draw any conclusions, but there are now other indications justifying the speculation that the Columbus Plan is beginning to roll, on the heels of increased public understanding of why some general practitioners charge so little and some surgeons charge so much.

In Indianapolis, where investigators had revealed a certain amount of unjustified surgery in two hospitals, fellows of the college in March 1953 formed the Indianapolis Surgical Society, in the pattern of the Columbus Plan. By early 1954, the society had 120 members, or more than half of the physicians doing major surgery in Indianapolis. While the first C. P. A. review of the members' accounts is not planned until early 1955, an official of the society not long ago said that, while there were some notable holdouts, the society was already having a "tremendous influence" for good, with indications of a considerable reduction in fee-splitting.

In Detroit, one of the cities where I interviewed admitted fee-splitters in 1946, the Detroit Surgical Society was founded almost simultaneously in April 1953 for the same purpose, and since has grown rapidly. By the time of the first audit, just completed in the last month, the Detroit society had 580 members, or two of every three physicians doing major surgery in that city, making it the largest implementation of the Columbus Plan to date. In the opinion of its leaders, the society already has greatly diminished fee-splitting. Early resistance from officials of the Detroit Academy of General Practice and of the Wayne County Medical Society has largely subsided. In one respect, the Detroit society went further than that in Columbus by requiring each member to consent to having the auditor interview his patients where necessary to verify amounts billed and paid.

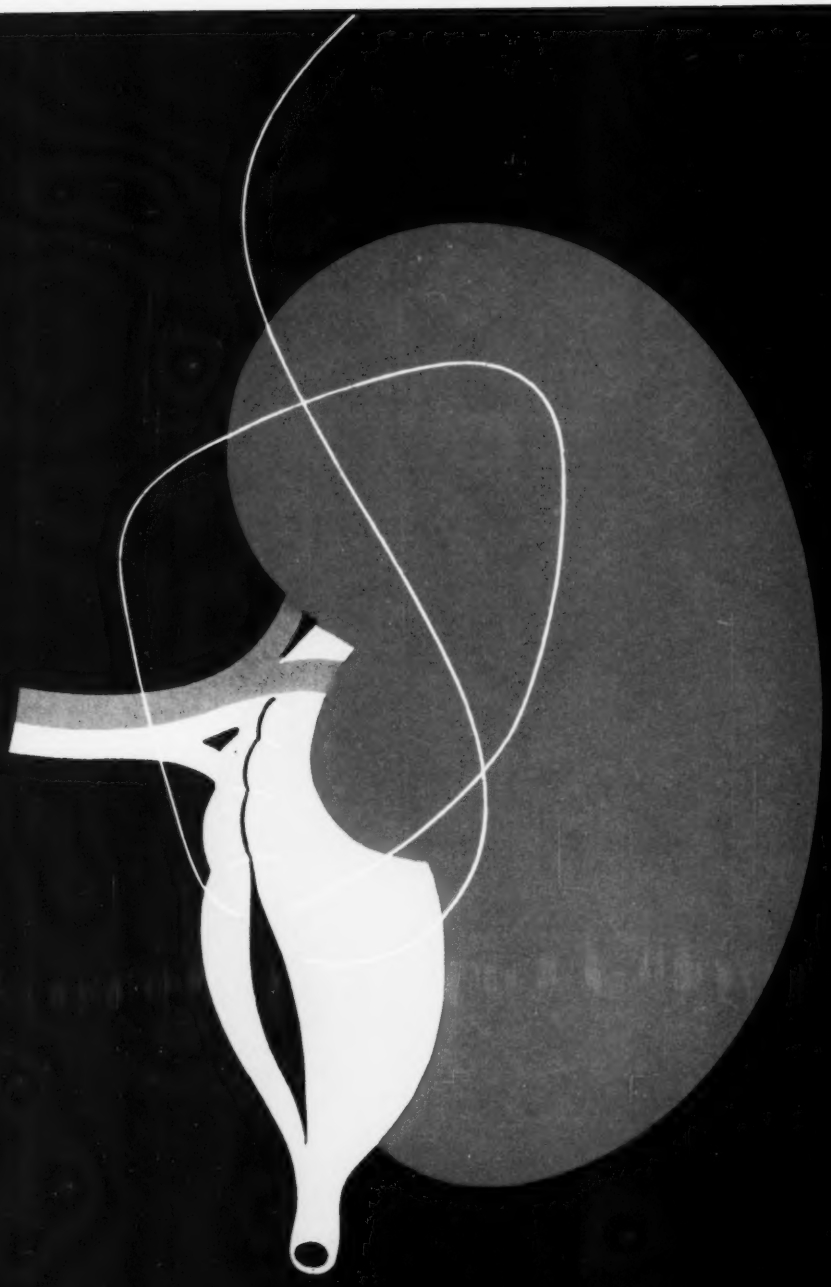
KEPT PAPERS INFORMED

The Detroit and Indianapolis surgeons followed the Columbus method in all particulars, with the important exceptions that they did not seek participation of all operating surgeons at the outset and, whereas the Columbus surgeons avoided any local press notice, those in Detroit and Indianapolis have kept the newspapers informed.

One weapon the Columbus Plan founders had hoped to develop, but which did not materialize, was a uniform requirement on the part of all Columbus hospitals that all members of their surgical staffs be members of the society; only two of the seven went that far, although the members of their staffs were almost all participants in the reform. In Indianapolis, the surgical society has the complete support of the staffs of two hospitals and substantial support from two of the other three, but no hospital requires that its surgeons be members of the society. In Detroit, the attitude among 29 hospitals ranges all the way from that of making society membership a basic requirement for staff appointment in the case of two (one in its by-laws and the other by staff desire) to complete indifference.

That the individual's maintenance of surgical privileges in one or more hospitals can be a key to the situation was recognized, of course, in the Bloomington modification of the Columbus Plan. Here the staff, rather than the society, was expected to furnish the pressure for uniform compliance.

A variation of the Bloomington approach was introduced in the Lincoln General Hospital of Lincoln, Neb., in February 1954, when the board of directors at the request of the staff re-



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wrote the hospital's by-laws, to make it possible for a majority of the members of the staff in any department of the hospital to request a financial audit on any member suspected of splitting fees. In April, the board of trustees of Bryan Memorial Hospital in Lincoln adopted a similar provision upon the recommendation of its staff. Lincoln General amended its by-laws to read:

"The Code of Ethics as adopted by the American Medical Association and the 'Principles of the Financial Relations in the Professional Care of the Patient' of the American College of Surgeons shall govern the professional conduct of the members of the medical staff. Specifically, all members of the medical staff shall pledge themselves that they will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services. On the contrary, it shall be agreed that all fees shall be collected and retained by the individual physician in accordance with the value of services rendered.

"Each staff member shall agree to make his financial books available to a Certified Public Accountant representing and employed by the medical staff for the purpose of proving his adherence to the Code. Such scrutiny shall be carried out upon the majority vote of the attending members of the department in which violation is suspected and the matter shall then be referred to the Credentials and Executive Committees for definitive action.

"A pledge to adhere to the requirements of this section shall be made in writing by all staff members before their appointment to the staff and before each annual reappointment."

Bryan Memorial put it this way:

"Each staff member shall agree to make his financial books available to a C.P.A. representing and employed by the medical staff of Bryan Memorial Hospital for the purpose of proving his adherence to the Code of Ethics as adopted by the American Medical Association and the 'Principles of the Financial Relations in the Professional Care of the Patient' of the American College of Surgeons. Such scrutiny shall be carried out upon the majority vote of the attending members of the department in which the violation is suspected. The matter, after investigation and with the C.P.A. report, shall then be referred to the executive committee for definitive action. The report of the findings of the C.P.A. shall only indicate whether or not the member being investigated is adhering to the Code of Ethics and the 'Principles of the Financial Relations in the Professional Care of the Patient' and in no wise shall reveal any of the physician's other financial dealings."

Undoubtedly, the most salutary feature of the Lincoln approach was that it constituted good public relations. It was the doctors themselves at Lincoln General who got the idea, which was hailed by the local press as good preventive medicine in a city where fee-splitting was pretty much a dead issue. Actually, it was a little more than that, in the opinion of one Lincoln surgeon who protested this interpretation. Before World War II, according to one of the reform leaders, fee-splitting was common in Lincoln, although greatly reduced by the advent during the previous 15 years of a good many qualified specialists. By the end of the war, the shortage of surgeons and a further influx of specialists reduced fee-splitting to a small but still persistent problem. According to this informant, the February action was "not an attempt to clean up Lincoln General Hospital but clean up the town."

Inevitably, such a move tends to single out the wayward and put pressure on them, and therefore is a step in the right direction. Students of fee-splitting reform, however, point out that while the C.P.A. threat when fee-splitting is suspected may be effective if the evil is a minor problem, anything less than a uniform, regular audit for everyone, or a certain proportion chosen at random, does not supply sufficient leverage to uproot the evil where it has become an accepted way of surgical life.

This need for routine rather than occasional application seems to have been recognized by Maimonides Hospital of Brooklyn, the sixth community in which the Columbus Plan or some modification of it has been introduced. The example set in Brooklyn, whose fee-splitting history has been favorably compared with the more flourishing Middle Western cities, was couched in a resolution recommended by the hospital's medical board and passed by its board of trustees in March 1954. The medical board stated that it wanted "to ensure that the high standards of its staff shall not be subjected to unjustified and unsupported attack upon any of its members" by adopting a method "to demonstrate the resolve of each of its physicians to maintain the highest professional and ethical standards," as follows:

"1. Every member of the present staff of Maimonides Hospital, and every future member, shall upon appointment execute a suitable undertaking not to engage in any form of fee-splitting, or the acceptance of rebates in any form.

"2. The medical board hereby appoints an Ethics and Audit Committee to be composed of four members of the Medical Board and the Medical Director of the hospital, which committee is empowered when it feels the need therefor, to engage the services of a qualified auditor.

"3. Every physician who holds a staff appointment at the hospital will agree that he may be, with or without cause being assigned therefor, directed by the Ethics and Audit Committee at any time, upon twenty days' notice, to submit, for any period on or after January 1, 1954, financial records, accounts, copies of income tax returns or any other relevant documents, papers or records for examination and inspection by the Ethics and Audit Committee and their auditor, and when required, personally appear before the aforesaid Committee to give account and explanation of any and all transactions had by such physician with his patients or others, related to his practice of medicine only.

"4. The failure of any physician to agree to the terms of the aforesaid resolution, as hereinabove set forth, or the failure to abide by the terms of said agreement, entitles the Medical Board to recommend the suspension of said physician from his staff appointment and privileges, and to recommend against his reappointment.

"5. A request of a physician for the production of his books and records shall be strictly confidential and be known only to the physician concerned and to the members of the Ethics and Audit Committee and their auditor, and under no circumstances shall the same be reported or communicated to any other person in or out of the hospital, unless and until specific charges are made against a physician, requiring the attention of the members of the Board of Trustees of the hospital, in which event, such information shall be reported to such Board or to the appropriate committee of said Board."

It was an interesting circumstance that the Maimonides resolution was drawn up with the assistance of the assistant attorney-general of New York State. The state has a law against fee-splitting, adopted following the disclosure in the 1944 Moreland Commission investigation of workmen's compensation graft in New York State that 3000 doctors in New York, Kings, Bronx and Queens counties were splitting fees.

The chief concern of the trustees of Maimonides in accepting the recommendation of their medical board was that the action would be construed as a self-accusation, but they were assured by the director of surgery that conditions were no better or worse in their hospital than any other and such action would now assure the community that the staff was entirely ethical. Conditions in Brooklyn, it must be granted, are more conducive to elimination of fee-splitting than in areas where inadequately trained physicians insist on doing major surgery or in assisting the surgeon, on a split basis. In Brooklyn, it has been the custom for general practitioners to do no more than minor surgery and the surgeons have generally employed their own assistants. Thus the surgery itself has been largely performed according to first-class standards, irrespective of any kickback aspect.

An authoritative commentator on

this ethical tree growing in Brooklyn made several statements of significance: "Fee-splitting is definitely on the decline, now that the public is aware of it. . . . More and more patients are demanding to be operated on in recognized, approved hospitals. . . . In our hospital, no one can scrub who is not a member of the surgical staff or house staff. No general practitioner scrubs. Otherwise, he is welcome. . . . The surgical staff is careful not to treat general practitioners as second-class citizens. We keep them fully informed on their patients. As a result, they cooperate in sending in patients for our Sunday morning follow-up clinic, and we know what kind of results we are getting."

STATEMENT BY A.C.S. REGENTS

Much of the impetus in this spread of the Columbus Plan appears to have come from the statement on the subject issued by the A.C.S. board of regents in October 1953, in response to accumulating requests for its advice on the formation of local societies organized to eradicate fee-splitting. The college stated that any such plan should encompass the following elements to assure effectiveness in any community:

"1. A strong desire among some part of the community's physicians who are doing the bulk of the surgery to stop fee-splitting. It has been generally observed that no surgeon likes to split fees, and that each surgeon will stop if he is convinced all will stop.

"2. A compelling reason for offenders to obey the ethical injunction against fee-splitting. The dictates of conscience, enough for some, are not sufficient for all. It is the history of human behavior that moral purpose frequently surrenders to economic pressure.

"3. A joint effort of doctors working together to bring about a reform or, in special circumstances, persuasive action by the hospital governing boards and their administrators, who control staff appointments.

"4. The formation of a local organization seeking the membership of all physicians doing surgery in the community's hospitals, irrespective of the individual doctor's qualifications. This group is organized primarily to promote ethical standards.

"5. The requirement, as a condition of membership, that each member of this organization submit his financial records, patient records and a copy of his income tax return to annual review by a certified public accountant — for evidence of fee-splitting only. This C.P.A. should be appointed by the Society and be responsible to an Audit Committee. He should be pledged not to reveal the income of a participating surgeon to anyone.

"6. Notification of the Internal Revenue Agent in charge of income investigations in the district of the aim and function of the above organization. If the State has a law prohibiting fee-splitting, it should be ascertained whether this Agent is disallowing split fees as a business expense deduction, in keeping with Internal Revenue Bureau policy stating that such deductions are against public policy in states having anti-fee-splitting laws. Irrespective of the law or the Agent's enforcement of policy, the organization should adopt the position, and so inform the Agent, that by its action the business deduction of split fees no longer can be regarded as a normal, usual and customary expense of doing business in the community, and therefore is disallowable according to Internal Revenue Service policy.

"7. Education of hospital governing bodies and their administrators to the evils of fee-splitting and the aim and function of the organization described, coupled with a request for the cooperation of the hospitals in securing the success of the reform."

The board of regents of the American College of Surgeons thus recognized the demonstrated value of the audit plan for the eradication of fee-splitting and recommended it for use by surgeons acting voluntarily together to wipe out this unethical practice in their own communities.

The latest and, it may be conceded, most dramatic application of the Columbus Plan method has been in the state of Iowa; here external pressure, as well as local initiative, was deemed necessary to protect the reputation of those Iowa fellows who had lived up to their pledges from the odium of the fact that their State Medical Society in the last two years has openly flouted the A.M.A.'s Principles of Medical Ethics.

Action to clear the names of Iowa fellows resulted from a long series of events. First and foremost was the fact that fee-splitting—in the form of a single bill and a secret kickback or a combined unitemized bill in which the split between referring physician and surgeon is acknowledged but not broken down—has been widely practiced in Iowa for a half century. Included among the fee-splitters were, it was suspected, some fellows of the college. Second, it became known that young, well trained, ethical surgeons going into the state to establish themselves in practice were running into economic boycotts from the unethical practitioners. Some were told they would starve if they didn't cut the referring physicians in.

Third, in 1951 internal revenue agents, pursuant to the previously established policy of the internal revenue commissioner that doctors' incomes fall in a special investigation category, began examination of the accounts of a large number of Iowa doctors, particularly surgeons. In consequence, these doctors were informed that their deductions as a business expense of fees paid to doctors not in their regular employ would be disallowed and considered a part of taxable income. According to one estimate, the doctors of Iowa stood to lose more than $3,000,000 as a result of this decision.

The argument of the unfortunate doctors that the splits paid out were a customary and necessary expense of business and therefore deductible ran into seeming conflict with the fact that the state of Iowa has a law defining fee-splitting as unprofessional conduct, an act for which a physician may have his license to practice revoked. This law defines this unethical conduct as follows:

"The division of fees or agreeing to split or divide the fees received for professional services with any person bringing or referring a patient or assisting in the care or treatment of a patient without the consent of the said patient or his legal representative."

ARGUMENT OVER WORDING

There has been some argument over the wording of this law, as to whether it meant that fee-splitting was all right if the patient consented, or actually described combined billing by referring physician and surgeon in the first part of the sentence, and meant ghost surgery in its reference to "assisting in the care or treatment of a patient without the consent of the said patient." In any event, the Iowa attorney-general has interpreted the law as permitting fee-splitting if done with the patient's knowledge. Represented by 50 attorneys, the Iowa doctors argued that combined billing by two independent doctors working together on the same case did not represent a payment for referral—even if one had referred the case to the other —but was a long-time custom generally known to patients. It had, it was argued, gone unchallenged for years. That was true. It had.

The internal revenue service indicated it would allow the deductions of splits—and subsequently did so—if the doctors in Iowa would provide satisfactory evidence that combined billing with the patient's consent was generally accepted and not illegal. The Iowa Academy of General Practice then called upon the Iowa State Med-

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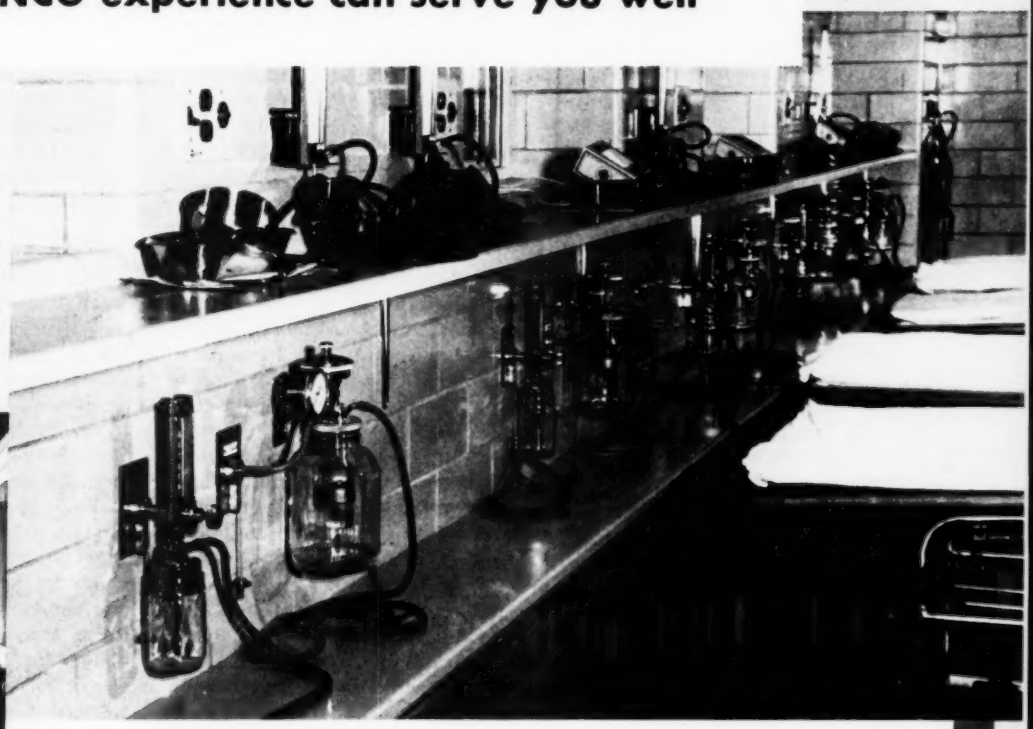

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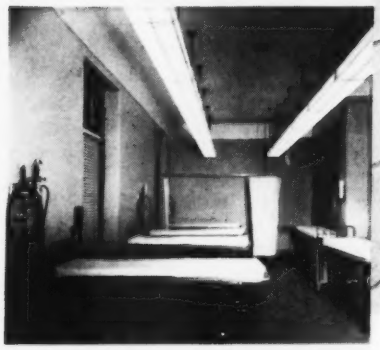

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ical Society to elaborate the A.M.A.'s code of ethics and state what was and was not ethical. In 1952, the society's executive council issued two elaborations, placing itself in the position of recommending that the referring physician assist the surgical specialist and go on the same combined unitemized bill with him. The fee, "to be divided equitably," could be collected by either doctor.

This, as far as known, constituted the first time that a constituent or component society of the A.M.A. had officially admitted that its members split fees; in fact, advocated that they do so. The Iowa society asked the A.M.A. Judicial Council to support its elaboration, but the Judicial Council in a ruling in December 1952 said combined billing was wrong—the only ethical thing for referring physician and surgeon to do was send separate bills. The ruling was adopted by the A.M.A. house of delegates. That was no help. The Iowa society in January 1953 elaborated its ethics for the third time, stating that two doctors rendering service to one patient could send individual bills if they wanted but that it was "accepted and approved" practice for them to submit a combined itemized bill, showing the names of the doctors and the respective amounts to be paid each doctor. This introduced the idea of itemization, but again placed the Iowa society squarely in conflict with A.M.A. ethical principles. It left only one hope, which was to secure a revision of the A.M.A. code to bring the rest of the medical profession into step with Iowa.

ONLY ONE CODE

Recognizing that there can be only one over-all code of medical ethics, the A.C.S. in March 1953 endorsed the Judicial Council's definition; subsequently, the college redefined its own interpretation of ethical principles, which had in 1952 offered no strong objection to combined itemized billing if the bill showed how much each doctor got and for what, and in which the charges of each were commensurate to his services to the patient; this was stated as intending to recognize the single-check practice followed by many insurance agencies in the payment of surgical claims covering the services of more than one doctor; it was not intended as a loophole for fee-splitters or hair-splitters.

At its June meeting in San Francisco, the A.M.A. house of delegates endeavored to decide what was fee-splitting and what was hair-splitting in two major actions. First, it adopted a new section, "Payment for Professional Services," replacing the old section, "Commissions," in the "Principles of Medical Ethics." This new section, proposed by the Council on Constitution and By-Laws, plunged boldly into the fee-splitting brier patch. It made it clear that each independent practitioner should inform the patient of his own fee. It established that the sin of fee-splitting lies in inducement of a patient referral through a system of patronage and reward. It spelled out various forms of monetary inducement, of which fee-splitting is but one, and said that the only ethical inducement is the quality of services offered. In a final paragraph, the new section, accepted by the house without discussion or opposition, took a dubious view of combined billing:

"Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor-patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care."

Nowhere did this change in the ethics support the argument of the American Academy of General Practice and the Iowa State Medical Society that fee-splitting means secret fee-splitting and becomes simply combined billing when the patient is told. Rather, the four-paragraph section stresses inducement as the nature of the wrongdoing, while granting that "unethical physicians . . . often utilize deception and coercion. . . ."

It has been officially stated that it is the function of the Principles of Medical Ethics to enunciate broad principles of ethical conduct and the function of the Judicial Council to interpret them. Thus, the crucial point was the Judicial Council's interpretation of an appeal from Iowa for recognition of combined itemized billing with either surgeon or general practitioner collecting the total fee and paying the other. Instead, the Judicial Council took note that some nonprofit insurance companies insist on a combined bill but usually pay by two checks. "This," it reported to the house of delegates, "is not considered unethical and all insurance plans which do not pay the individual physician in this manner should be urged to do so." The report then continued:

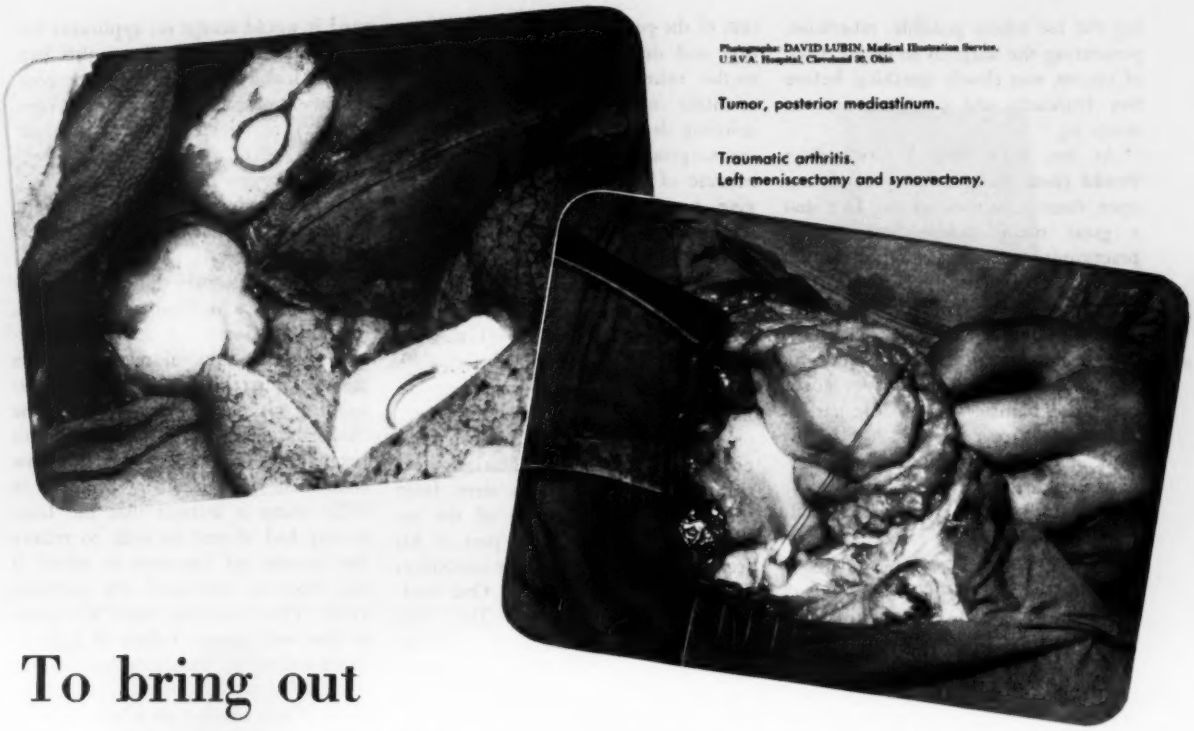
"The Judicial Council is still of the opinion that when two or more physicians actually and in person render service to one patient they should render separate bills.

"There are cases, however, where the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur it is considered ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fee charged. The amount of the fee charged should be paid directly to the individual physicians who rendered the service in question."

ADOPTED AS OFFICIAL POLICY

This report was adopted by the house of delegates as official A.M.A. policy over the protests of two past A.M.A. presidents, Drs. John Cline of San Francisco and Louis H. Bauer of Hempstead, N.Y., both of whom argued that the permission of combined billing for any reason except insurance claims "opens the way for unethical physicians to split fees" and laid the A.M.A. open to public criticism for not taking a clear, strong stand. Dr. George Braunlich of Davenport, Iowa, author of the Iowa resolution, argued the case for combined billing. At one point, Dr. Braunlich charged the A.C.S.'s fight against fee-splitting was "just a screen to enable the surgeon to get all the money." A little later, while endeavoring to establish that "fee-splitting" and "division of the fee" are altogether different things, one bad and one good, he produced general laughter among the delegates.

The acceptance of combined itemized billing as ethical appeared to be a classic compromise, borrowing one element of separate billing, which is separate payment, and one element of fee-splitting, which is combined billing. Whether the compromise will be a happy one is a question. Itemization imposes on the referring physician the task of justifying his fee and separate payment presents him some difficulty in collection. By and large, the preferred system in the fee-splitting communities of the Middle West has been combined *un*itemized billing, with the general practitioner collect-



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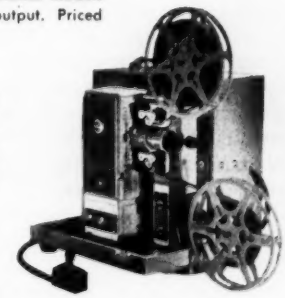

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ing the fee where possible, otherwise, permitting the surgeon to do so. This, of course, was clearly unethical before San Francisco and continues just as much so.

As has been said before, ethics should close doors to temptation, not open them. In view of the fact that a great many independent general practitioners in this country do not demand a split of the surgeon's fee directly or under guise of assistance, and in view of the fact that some physicians do split fees in secret or by subterfuge, then the desire for a combined itemized bill on the part of independent practitioners not legally associated with one another in a clinic or a partnership must remain suspect. The doctor's motives may be perfectly honest, but it is the camel's nose in the tent; it opens the way for deception of the patient and inducement for referral.

KEEPS STANDARDS DOWN

Beyond the question of motive, fee-splitting in any form tends to hold down standards of surgical care in opposition to efforts to raise them. It is a shell-game maneuver to correct the inequity of the surgical and medical fee system by exploiting the preferred creditor position and sales appeal of the surgeon, rather than by any direct or public educational effort to reduce the surgeon's fee and raise the general practitioner's fee. Fee-splitting persuades those who participate in it to oppose and to boycott those who insist on rendering their own bills for their own services only. It alters the doctor-patient relationship between the referring physician and his patient, whom the doctor is hired to serve and represent, by introducing into this contractual understanding a third party, the surgeon who offers a reward for business turned his way. Fee-splitting tends to turn the general practitioner's properly conservative attitude toward surgery to one of enthusiasm for it, so that he may not only consider a surgical approach but now insist on it, whatever the surgeon's judgment. It encourages the surgeon to employ the referring physician as a surgical assistant irrespective of the latter's qualifications to assist, a practice working against the use of a regular assistant and therefore the continuity and efficiency of the surgical team. It encourages the surgeon to shift the burden of his responsibility for accurate diagnosis, proper preparation of the patient, postoperative attention and determination of his result to the "other guy," and therefore lose scientific interest in his work. Fee-splitting destroys the essential rôle of the surgeon as a consultant called on because of training and experience to give an objective and independent opinion.

Whereas proponents of combined billing, mainly spokesmen for general practitioners, sometimes have attributed the A.C.S. attack on fee-splitting to "the surgeon's desire to keep the whole fee," any thoughtful attention to human motivation will convince one, on the contrary, of two notable tendencies often seen in notorious fee-splitting surgeons. Both stem from the understandable desire of the individual to make up the part of his fee—usually half—which he surrenders to the referring physician. One tendency is to raise the fee. The other tendency is to make up the loss by operating more often. In one direction may lie fee-gouging; in the other, unjustified surgery.

On the subject of human behavior, as well as economic realism, few persons are opposed to making more money. It follows therefore that no person would give away half of his income if he did not find it necessary. If it was unnecessary for the fee-splitting surgeon to do so, it follows he might be disposed to do fewer cases for a given fee. He could then give them far more diagnostic, preparatory, operative and follow-up attention to be sure of the indications for surgery and to reckon with the outcome of his work, as well as to study the work of others in his field. Such a possibility opens the way for elimination of countless operations based on an incorrect diagnosis or faulty judgment as to the need of operation, and to a reduction of incompetent performances and bad results. In this direction lies needed improvement in the quality of medical and surgical care widely available to the American people. Such a course is, of course, unassailable.

Such was the philosophy of college officials when the Iowa State Medical Society served notice on the A.M.A. and the A.C.S. that Iowa was, so to speak, an ethically independent, free-splitting state. This meant that Iowa F.A.C.S.'s, if they followed "approved" practice, would be violating their pledge to the college not to split fees. For the time being, the college indicated it would accept no applicants for fellowship from Iowa. Later this ban was rescinded insofar as a few demonstrably simon-pure surgeons were concerned; it remained in effect against all doubtful areas.

The charges have been made—in fact were made by the then president of the Iowa society before the reference committee on legislation and public relations at the June 1953 meeting of the A.M.A.—that the A.C.S. had chosen Iowa for attack, was responsible for internal revenue agents coming into the state and was persecuting its own members. These charges were false and libelous, if not paranoid. The college first became concerned with the Iowa problem in 1952 when it learned that the Iowa society had altered its code to relieve the income tax situation in which it had become enmeshed the previous year. Thus a reverse twist was given to that well known fallacy of logic in cause-and-effect relationships known as *post hoc ergo propter hoc;* an earlier "effect" was blamed on a later "cause."

WILL USE COLUMBUS PLAN

As a result of a conference of two regents with a group of 16 Iowa fellows, the A.C.S. board of regents at its meeting this May decided that the Columbus Plan method should be employed to establish that Iowa F.A.C.S.'s are ethical surgeons. Those who refuse to submit to a financial audit for evidence of fee-splitting will be given an opportunity to resign. Those refusing the audit and not resigning will be expelled. The date of the first audit has not been announced; if the Columbus Plan pattern is followed in this instance, however, it may be assumed that the first C.P.A. checkup will be carried out following a period of forgiveness. Likewise, the action will require all new applicants for fellowship from Iowa to agree to an audit.

Thus it has been demonstrated to the public and to the profession that the American College of Surgeons has the courage of its convictions and means business in its campaign against unethical practices. Expressing the hope that Iowa will become the first state to utilize the C.P.A. method to wipe out fee-splitting, Dr. Evarts A. Graham, chairman of the board of regents, predicted that if the Iowa movement is successful the college may impose the requirement in other trouble spots.

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For the benefit of the smaller hospitals Georgia offers a program for

Training Food Service Employes

MARGARET DYKES

Dietary Consultant, Division of Hospital Services
Georgia Department of Public Health, Atlanta

A VITAL need for trained dietary employes for the smaller hospitals exists in all states. In Georgia the division of hospital services of the state department of public health has made a beginning in planning training programs for dietary employes.

Since there is a severe shortage of trained dietitians available and since it would be difficult for the smaller hospitals to pay salaries to attract professional people, the first need is for food service supervisors who can be responsible for the successful operation of the dietary department under the guidance of the administrator. With this need in mind, the school of home economics at the University of Georgia and the state's division of hospital services have planned a college course of instruction for food service supervisors and directors of hospital food service in the smaller hospitals. The course, open to high school graduates, consists of three quarters of regular college work to be followed by three months of practical experience in selected hospitals in the state. This one-year course is also being offered for school lunch personnel.

Another approach to this problem has been that of conducting workshops for hospital food service personnel. In the summer of 1952, such a workshop was held at the University of Georgia, with staff members of the school of home economics, dietary consultant of the division of hospital services, and qualified personnel from state and federal agencies, including hospitals, serving as instructors. Oral discussion and written evaluation sheets indicated that another workshop should be offered in the summer of 1953. In planning the second workshop, emphasis was placed on the areas of training requested by the participants and felt to be important by the instructors.

Some attention has been given by our division to plans for in-service training courses to be given in local communities for both supervisors and employes in hospital dietary departments. Georgia is divided into five hospital council areas in addition to metropolitan Atlanta and the courses would be arranged with the assistance of these councils. It is hoped that at least one course can be offered in each area this year. Plans are to have each course include five two-hour classes, one to be held each week. Local hospital personnel are to assist in developing these plans, and resource persons in the various communities will serve as staff members to conduct the classes.

As dietary consultant for the division of hospital services, I have worked on the development of materials and information to be used by dietary departments in the smaller hospitals. The Georgia Hospital Diet Manual, which was distributed early in March, will serve as a guide to the food service supervisor in planning modified diets and can be used in training employes to prepare and serve these diets. When I visit hospitals, I give supervisors samples of materials available with directions for their use. Much training is done on such an individual basis. This, of course, is time consuming, but it can prove a valuable method of training dietary employes, particularly supervisors. The employes are in their own departments where the solution to a problem can immediately be applied.

Several record keeping forms also have been developed for use in the dietary department. These forms were based on the cost accounting forms developed by the American Hospital Association, but they are simpler and easier for a smaller hospital to handle. These forms are discussed with administrators and food service supervisors when hospital visits are made. The meal count and physical inventory forms have been found to be especially useful.

Still another approach to training dietary employes for smaller hospitals has been that of working closely with the staff just prior to opening a new hospital.

A 27 bed hospital, for example, had made plans to have its dedication on

This is the second article by Miss Dykes on the dietary consultant program in Georgia. The first appeared in the July issue of The Modern Hospital under the title, "Take Your Troubles to a Consultant."

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February 15 and to admit patients the next day. Early in January the administrator requested the help of the dietary consultant in purchasing storeroom food items prior to opening date. This administrator is a registered nurse and she expected to have general supervision of the dietary department, including menu planning and purchasing. I visited the hospital and helped the administrator make out the market order. We discussed prices with several wholesale companies before placing the orders. Deliveries were made about two weeks prior to opening the hospital. One dietary aide was already on duty at this time, and she had been designated to do the record keeping for the dietary department. Using the physical inventory form mentioned earlier, she transferred all items from invoices after supplies were checked in and calculated unit costs for future use. I gave her assistance in this work.

ORGANIZED THE DEPARTMENT

Two weeks prior to the dedication, I made another visit to this hospital. At this time, I met with the administrator and all dietary employes for the purpose of organizing the department. We discussed the various areas of operation and made a plan of organization, including work schedules for all dietary employes, personnel policies for this department, the meal schedule, and general rules and regulations. We made plans for the mechanics involved in setting up trays for patient meals and for serving hospital personnel. The heavy duty equipment was checked for operation and maintenance, and defects of installation or operation were referred to the proper persons. Working as a group on the organization of the dietary department made the employes feel it was their department, that they were having a real part in planning its operation, and that they were in position to serve as part of the team in providing good care for the patient.

The dedication of the hospital was held on the morning of February 15. The dietary staff made last minute preparation for serving the noon meal the following day. The light equipment had been washed and stored properly just prior to the dedication. That afternoon the dishes, silver and glassware were washed and stored. A demonstration was given in setting up trays for breakfast, dinner and supper; also liquid trays. It was interesting to note that the dietary aide who was to

be responsible for this duty, without prompting, made a diagram of each tray for future reference. Patients were admitted the next morning. As dietary consultant, I spent most of that day at the hospital and helped serve the first meal. The dietary employes were intelligent people, interested in doing a good job. And the administrator, who was to have multiple duties, was sincerely interested in having as much help as possible in getting the department organized prior to its actual operation.

Reports from staff members in our office who have visited the hospital since it opened mention that the food is good and that things seem to be running as smoothly as if the hospital had been operating for a long time. I have made two follow-up visits and am convinced that our efforts were worth while.

ESTABLISH POLICIES FIRST

Perhaps food service supervisors are interested in some suggestions for training dietary employes. First of all, the supervisor should start with a good plan of organization. This includes establishing such personnel policies as rates of pay, hours of work, days off duty, vacation privileges, and sick leave. A job analysis should be made to determine the number of employes needed and what their work schedules and duties should be.

"Help others when not busy" is a good motto to list as a duty on each schedule. General rules should be established to cover such items as mode of dress, smoking, and use of telephone for personal calls.

When it becomes necessary to employ a new person, an interview with the prospective employe should be held. Information about former training, experience, former jobs, reason for leaving last job, and personal references can be reviewed. Personnel policies and rules and regulations of the hospital should also be discussed. Then the employe's training should begin with discussion of the duties and responsibilities of the job to be filled.

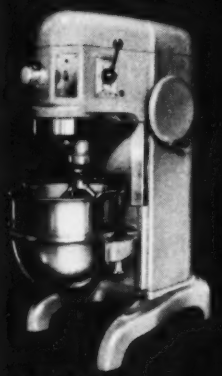
An important part of employe training is to show the employe *how* to do a job. It is the responsibility of the supervisor to see that each employe understands his job and knows how to use the tools he must work with, whether they are recipes, fuel or mop and broom. After helping the employe get acquainted with his job, she should leave him on his own for a while, and then follow up her previous instruction. If he is not doing a satisfactory job, she should try to determine whether his poor performance is due to his inability or to her inadequate teaching. If he cannot measure up after good and ample help, he should be replaced with a more capable person.

EMPLOYE MEETINGS HELPFUL

One of the most effective methods of keeping a dietary department operating smoothly is to have regular meetings with all employes. At this time, new policies can be explained, problems can be discussed objectively, and questions can be answered. Such a meeting gives everyone an opportunity actually to participate in the operation of the department. It is also an excellent way for the supervisor to develop and maintain the respect, loyalty and cooperation of her employes.

The *why* of this business of training dietary employes is for this department to do its part in providing good patient care. Then, too, it is necessary to have good employe relations within the dietary departments as well as good public relations provided through the medium of good food served to the patient. To accomplish these two goals, a food service supervisor must be well versed in the know-how of operating her department, yet be able to delegate responsibility to her employes in order to have the time necessary for general supervision and administrative work. She must be tactful and diplomatic in the handling of all personnel problems. These characteristics are also necessary in her contacts with her supervisor, her coworkers, vendors and the public at large. Good health is necessary because her work is strenuous.

It takes time, effort, patience and interest to carry on a good training program. The job is a challenging one to the food service supervisor who is vitally interested in rendering a valuable service to persons who need it.



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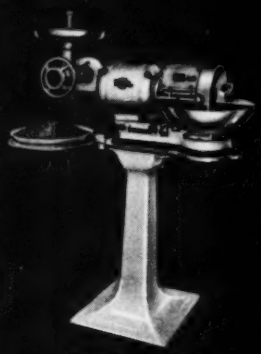

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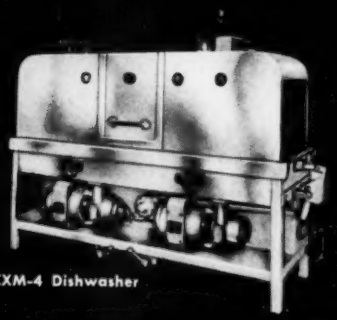

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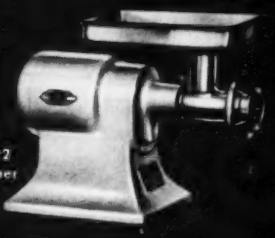

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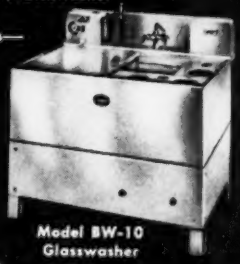

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FOOD FOR THOUGHT

Thaw Meat Before Cooking?

Should frozen meat be thawed before cooking, or will it cook as successfully if started hard-frozen? Faith Fenton, New York State Experiment Station, says completely thawed meat may be cooked like fresh meat, but should be used soon after thawing to avoid excessive juice loss. Meats—especially large pieces—cook more evenly if thawed in advance. But if some customers like meat rare and others like it well done, put meat on to cook still hard-frozen.

No difference in palatability, nutritive value, evaporation or "total drip" has been found, Dr. Fenton reports, whether meat is thawed during cooking, at room temperature, or in the refrigerator. Some meats need to be thawed in advance in order to prepare them for cooking. For example, small pieces of stew meat frozen together need to be thawed to separate them for browning; meat to be coated with eggs and crumbs or batter needs thawing because the coating won't hold to frozen meat, and ground meat may need thawing in order to season it evenly. Let meat thaw in its freezer-wrap to prevent drying by evaporation. Frozen meat takes longer to cook than does thawed meat; roasts take twice as long to cook rare, three times as long to cook well done as fresh or thawed roasts.

Here are approximate thawing times as a guide for the cook's convenience.

Thawed in the refrigerator (40 to 50° F.) steaks an inch thick take 12 hours; small roasts, 3 to 4 hours a pound; large roasts, 4 to 6 hours a pound.

Thawing at room temperature (70 to 75° F.) inch-thick steaks take 2 to 3 hours; small roasts, 1 to 2 hours per pound; large roasts, 2 to 3 hours per pound.

Fastest method of thawing is with an electric fan. Dr. Fenton does not recommend this method for large roasts, however, because meat does not thaw evenly and there is excessive loss of juice from the outer, thawed part of the roast. Thawed by an electric fan, inch-thick steaks take 1 to 2 hours; small roasts take 1½ to 2 hours a pound.

Thawing meat under cold running water is not recommended by Dr. Fenton because the meat tends to gain water even though it is wrapped.

Freezing Sandwiches

Fillings suitable for sandwiches to be frozen include: luncheon meats, leftover sliced roast beef, roast pork, baked ham, chicken, turkey, dried beef, tuna, salmon, sliced cheese, cheese spreads, yolks of hard cooked eggs, and peanut butter. Use separately or combine with cream cheese, creamed butter, mayonnaise or salad dressing. Add sliced or chopped olives and dill or sweet pickles if desired.

For safety freeze only freshly prepared sandwiches and fillings. Avoid raw vegetables such as lettuce, celery, tomatoes and watercress which lose crispness, color and flavor when frozen; whites of hard cooked eggs which become tough; or fruit jellies or preserves which soak into bread. Spread bread with softened butter or margarine, not with salad dressing or mayonnaise which soaks into bread. Once frozen sandwiches are thawed, use them promptly because they spoil rapidly after they have warmed up to temperatures above 45° F.

Wrap each sandwich in a double thickness of heavy waxed paper or with moisture-vapor-resistant wrapping, folded tight. Freeze and store at 0° F. or below. In heavy waxed paper sandwiches keep fresh in the freezer a week; in moisture-vapor-resistant wrapping they may be stored two to three weeks. Thawing at room temperature takes about three hours.

New Booklet on Clam Cookery

Twenty-seven choice recipes for cooking clams are contained in a new publication released by the Fish and Wildlife Service, Department of the Interior. These recipes, which are presented in "How to Cook Clams," were developed by home economists of the Service at Seattle, Wash., and College Park, Md.

Many traditions have grown up around the serving and eating of clams. Annual clam-eating contests are held in various coastal regions of the country. The connotations of the term

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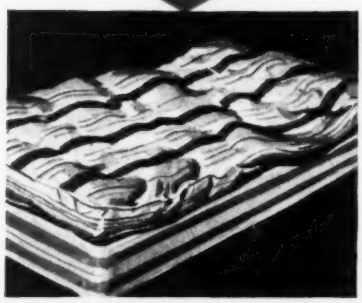

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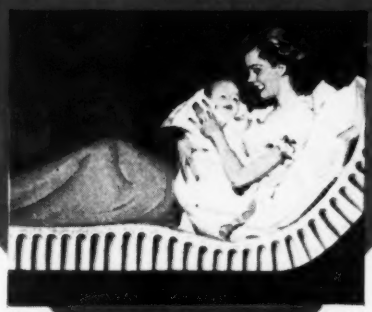

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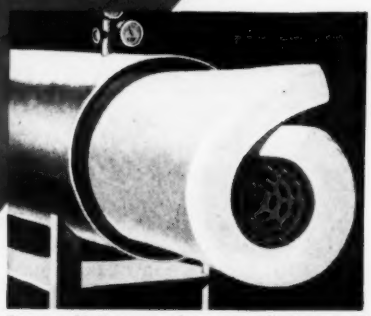

Foamex Mattresses give year after year of clean, fresh service...withstand constant wettings...discourage pests and insects...stand up under washing and sterilization.

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Best of all, you get Firestone Foamex Mattresses...fast! They're made by the world's most extensive network of local manufacturers. It's likely that there's one within the same-day shipping distance from you...ready to meet your needs. Why not contact your local Foamex mattress supplier or any one of the Foamex Sales Offices listed below for samples and information.

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"clambake" have extended the use of that word far beyond its original meaning. Few controversies (in cooking circles, at least) have more participants than that which centers on the proper way to make clam chowder.

Several species of clams are widely used for food, with the market varieties of the East Coast differing from those of the West Coast.

On the Atlantic Coast, the marketed species are the hard clam, the soft clam, and the surf clam. The hard clam, or hard-shell clam, is commonly called "quahog" in New England where "clam" generally means the soft-shell variety. In the Middle Atlantic states and southward, "clam" is the usual name for the hard clam.

Littlenecks and cherrystones are dealers' names for the smaller sized hard clams, generally served raw on the half shell. The larger sizes of hard clams are called chowders and are used mainly for chowders and soups. The larger sizes of soft clams are known as "in-shells" and the smaller sizes as "steamers."

On the Pacific Coast, the commonest market species are the butter, littleneck, razor, and pismo clams. The Pacific littleneck clam is a different species from the Atlantic hard clam.

On each of our coasts are areas famous for the quality of their clams. Notable among these are Pismo Beach in California, whence comes the delicious pismo clam, and Long Beach in Washington, famous for the razor clam. On the Atlantic Coast, many areas are noted for their "cherrystones," soft clams, and surf clams.

Although clams are served oftenest in chowders, there are many good ways to serve them. It is not only the fine distinctive flavor that recommends them as a food; they are also an excellent source of the "protective" nutrients, including proteins, minerals and vitamins.

Some of the easy-to-prepare yet out-of-the-ordinary recipes included in the new publication are stuffed clams, clam au gratin, clam poulette, deviled clam loaf, baked clam hash, sour cream clam pie, clam and spaghetti casserole, and clam and ham scramble.

Generously illustrated, "How to Cook Clams" is No. 8 in the Service's Test Kitchen Series of fish cookery publications, for sale at 20 cents a copy by the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Frozen Fruit Pack

This year's commercial pack of frozen fruits and fruit juices is expected to top last year's pack of 1,300,000,000 pounds, according to the U.S. Department of Agriculture. The much larger pack of frozen Florida citrus juices will account for the larger total pack this year. The pack of frozen fruits and berries, other than citrus, probably will be somewhat smaller this year. Prospects are that fewer sour cherries will be frozen because of a much smaller crop in Michigan, one of the most important sour cherry states. Then, the strawberry crop in Washington and Oregon is smaller this year than last. Most commercially frozen strawberries are grown in the three states of Washington, Oregon and California.

Strawberries are among the most popular frozen fruits and usually are frozen in larger quantity than any other fruit. The 1953 pack of frozen strawberries amounted to 226,000,000 pounds. This was a good sized share of the 542,000,000 pounds of all non-citrus fruits and berries commercially frozen last year.

ideas

from Blickman-Built award-winning food service installations

"planned work flow" promotes kitchen staff productivity

AT BETH-EL HOSPITAL, BROOKLYN, N. Y.

COOKING SECTION, MAIN KITCHEN: Food conveyor traffic flows rapidly around this section in a counter-clockwise direction. Ample work surfaces are provided by the generously-proportioned cooks' tables. Note seamless work tops, rounded corners, welded tubular undershelves.

• Careful planning, based on work flow studies, is the key factor in the successful operation of Beth-El Hospital's food service installation. Both layout and equipment have been designed to function like a factory production line in serving approximately 50,000 meals per month. Large work areas with wide traffic aisles ensure rapid work flow and increase the productivity of kitchen labor. The modern stainless steel equipment embodies important features of utility and sanitation. These not only facilitate the overall operation, but reduce cleaning and maintenance costs as well.

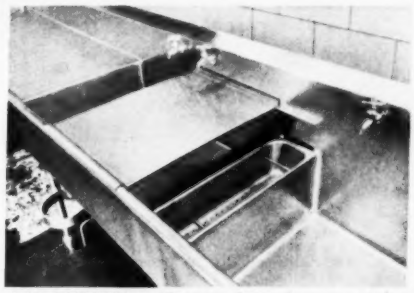
Service to patients is provided through a decentralized system. Electrically-heated food conveyors are wheeled around the island cooking section in a counter-clockwise direction. They are loaded with foods at the cooking center, bakery and finally the daily stores section. Then, they are taken to individual floor pantries where set-up trays are loaded and placed in tray carts for distribution to patients. Each floor pantry is completely equipped with short order units, refrigerators, dish storage and washing facilities.

This installation, winner of a Merit Award in a recent Institutions Food Service Contest, was designed and equipped by S. Blickman, Inc. You, too, can attain top efficiency and economy in your dietary department by installing "Blickman-Built" equipment.

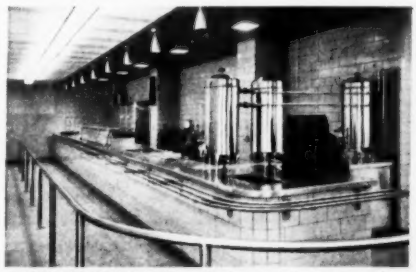
***Send for illustrated folder** describing Blickman-Built Food Service Equipment — available in single units or complete installations.*

S. Blickman, Inc., 1508 Gregory Ave., Weehawken, N. J.

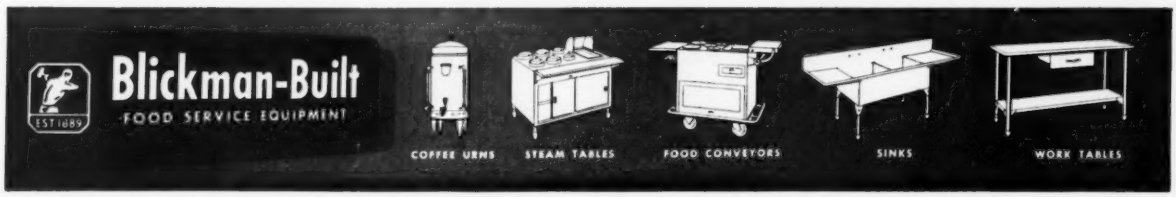
STAINLESS STEEL DISH TABLES in dish pantry. Work top and raised rolled edges form a continuous, crevice-free surface to assure maximum cleanliness.



POT SCULLERY — Close-up of round-corner stainless steel pot and pan sink. Compartments, drainboard and back splash form one continuous crevice-free surface, simplifying cleaning. The sliding tray permits placing of pots at convenient work height.



STAFF CAFETERIA accommodates visitors as well as hospital employees. Pass-through refrigerator at rear provides access to kitchen, eliminating waste motion and cross-traffic. Counter top is of stainless steel.



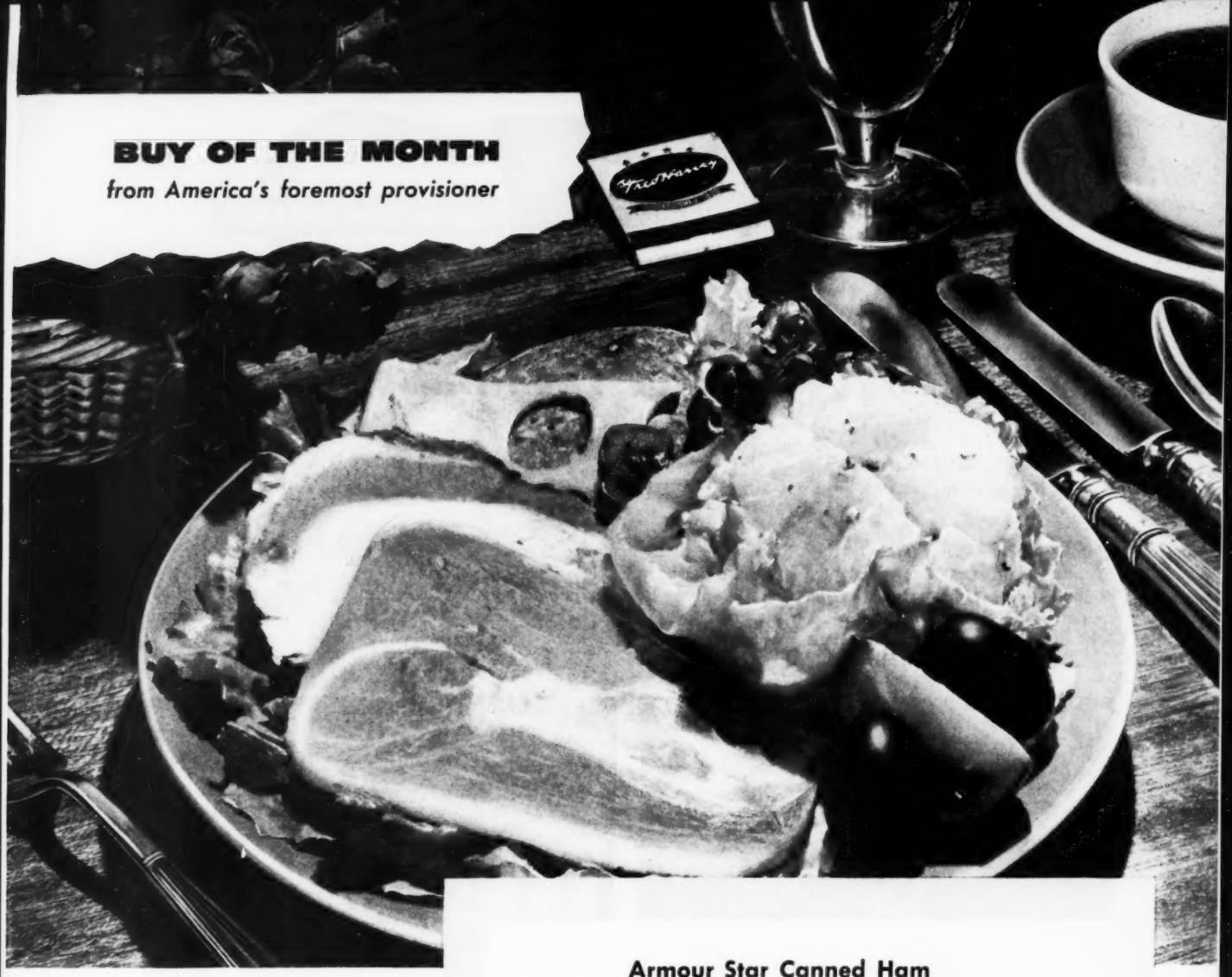
You are welcome to our exhibit at the American Hospital Association Convention, Navy Pier, Booth No. 315, Chicago, Illinois, September 13-16.

Menus for September 1954

Corinne Catlin
Dietitian
Welborn Memorial Baptist Hospital
Evansville, Ind.

1 Orange Juice Scrambled Eggs, Toast • Scotch Broth Roast Chicken Mashed Potatoes Buttered Peas Pickled Beets Chocolate Sundae • Vegetable Soup Tuna Fish Salad Potato Chips Stuffed Celery Sliced Peaches	**2** Grapefruit Half Bacon, Muffin • Beef Noodle Soup Breaded Veal Cutlets, Mushroom Sauce Parslied Potatoes Glazed Carrots Hearts of Lettuce, 1000 Island Dressing Cherry Upside Down Cake • Cream of Celery Soup Fruit Salad Plate With Cream Cheese Assorted Sandwiches Baked Potato Vanilla Ice Cream	**3** Pineapple Juice Poached Egg on Toast • Cream of Asparagus Soup Broiled Perch Escalloped Potatoes Buttered Lima Beans Ribbon Gelatin Salad Apple Crisp • Tomato Soup Salmon With Noodles Buttered Green Beans Celery Cabbage, French Dressing Chocolate Pudding	**4** Cantaloupe Sausage Links, Roll • Chicken Rice Soup Roast Loin of Pork Mashed Potatoes Buttered Brussels Sprouts Waldorf Salad Lemon Chiffon Pie With Graham Cracker Crust • Pepper Pot Soup Chicken à la King Buttered Asparagus Tips Sliced Tomatoes Green Gage Plums	**5** Blended Citrus Juice Egg Pancakes, Sirup • Jellied Consommé Swiss Steak Baked Potato Buttered Asparagus Tossed Salad, Holland Dressing Tapioca Cream • Chicken Gumbo Soup Bacon, Lettuce and Tomato Sandwich Buttered Broccoli Cottage Cheese and Olive Salad Baked Apple	**6** Banana Soft Cooked Egg, Toast • Vegetable Juice Roast Beef, Gravy Mashed Potatoes Cauliflower With Cheese Sauce Arabian Peach Mold Lemon Sherbet • Cream of Spinach Soup Assorted Cold Cuts Macaroni Salad Buttered Wax Beans Sliced Tomatoes Norwegian Prune Pudding
7 Honey Dew Melon Bacon, Muffin • Cream of Mushroom Soup Roast Leg of Lamb, Mint Jelly Parslied Potatoes Buttered Beets Tossed Salad Pineapple Sherbet • Vegetable Soup Hamburger on Bun Potato Chips Creamed Carrots Relishes Whole Peeled Apricots	**8** Grapefruit Juice Scrambled Eggs, Toast • Cream of Celery Soup Roast Leg of Veal Buttered Potatoes Parslied Wax Beans Sliced Tomato Vanilla Ice Cream, Wafers • Noodle Soup Cheese Soufflé Creamed Peas Waldorf Salad Fresh Grapes, Cookies	**9** Prunes With Lemon Juice Sausage Links, Muffin • Consommé Southern Fried Chicken Mashed Potatoes, Gravy Cauliflower au Gratin Relishes Fresh Fruit Cup • Cream of Vegetable Soup Creole Spaghetti Buttered Green Beans Pear and Cottage Cheese Salad Coconut Pudding	**10** Orange Juice Poached Egg on Toast • Barley Soup Baked White Fish, Tartare Sauce French Fried Potatoes Creamed Peas Mixed Fruit Salad Chocolate Cake • Tomato Juice Tuna Fish and Noodle Casserole Buttered Corn Carrot and Celery Sticks Watermelon	**11** Pineapple Juice Griddle Cakes, Sirup • Beef Broth With Rice Chopped Swiss Steak Buttered Potatoes Creamed Peas and Carrots Perfection Salad Sliced Fresh Peaches • Cream of Pea Soup Chicken Salad in Tomato Cups Potato Chips Asparagus Tips in Vinaigrette Pineapple Upside Down Cake	**12** Banana Fried Egg, Roll • Grapefruit Juice Baked Ham German Potato Salad Broccoli With Hollandaise Sauce Celery Hearts Cherry Cobbler • Chicken Noodle Soup Baked Beef Heart, Dressing Spinach, Egg Slices Mexican Coleslaw Applesauce
13 Blended Citrus Juice Bacon, Muffin • Chicken Noodle Soup Braised Short Ribs of Beef Buttered Lima Beans Banana Nut Salad Strawberry Parfait Pie • Alphabet Soup Eggs à la Goldenrod Buttered Green Beans Sliced Tomatoes Fruit Gelatin	**14** Grapefruit Half Soft Cooked Egg, Toast • Cream of Tomato Soup Veal Birds Potatoes au Gratin Glazed Carrots Lettuce Wedge, Roquefort Dressing Bavarian Cream • Chicken Gumbo Soup Frankfurter on Bun Harvard Beets Prune and Cheese Salad Apricot Halves	**15** Orange Half Sausage Links, Roll • Cream of Asparagus Soup Grilled Salisbury Steak Parslied Potatoes Mashed Turnips Molded Fruit Salad Banana Ice Cream • Barley Soup Salmon Loaf Buttered Lima Beans Stuffed Celery Fruit Cup	**16** Prune Juice Fried Egg, Toast • Beef Noodle Soup Browned Spareribs Mashed Potatoes Sauerkraut Tomato-Cucumber Salad Chocolate Pie • Jellied Consommé Creamed Turkey on Toast Buttered Broccoli Pear and Orange Salad Spice Cake	**17** Tomato Juice Pancakes, Sirup • Vegetable Soup Shrimp Creole Buttered Peas Tossed Salad, Blue Cheese Dressing Lemon Snow Custard • Corn Chowder Tuna Salad Potato Chips Assorted Relishes Iced Cup Cakes	**18** Cantaloupe Poached Egg on Toast • Tomato Rice Soup Broiled Pork Chop Lyonnaise Potatoes Cabbage au Gratin Lime-Grapefruit Salad Cherry Pie • Chicken Gumbo Soup Creamed Sweet Breads on Toast Spiced Beets Hearts of Lettuce, Russian Dressing Raspberry Sherbet
19 Blended Citrus Juice Bacon, Sweet Roll • Cream of Mushroom Soup Pot Roast of Beef Browned Potatoes Fried Egg Plant Tomato Wedge Baked Custard • Pepper Pot Soup Grilled Cheese Sandwich Buttered Spinach Coleslaw Boysenberries	**20** Banana Scrambled Egg, Toast • Tomato Bouillon Braised Liver, Onions Escalloped Potatoes Buttered Succotash Asparagus Salad Peppermint Candy Ice Cream • Beef Rice Soup Chicken Pie With Biscuits Buttered Peas Carrot and Celery Sticks Pears, Cookie	**21** Cantaloupe French Toast, Sirup • Scotch Broth Lamb Fricassee Lyonnaise Potatoes Hot Pickled Beets Tossed Salad Fruit Gelatin • Cream of Asparagus Soup Cold Sliced Tongue Baked Potato With Cheese Buttered Wax Beans Perfection Salad Baked Apple	**22** Grapefruit Juice Sausage, Muffin • Cream of Mushroom Soup Fried Ham Stuffed Baked Potatoes Parslied Carrots Pineapple and Grated Cheese Salad Gingerbread With Whipped Cream • French Onion Soup Meat Balls With Rice Buttered Green Beans Banana, Orange and Nuts in Lime Gelatin Bing Cherries	**23** Orange Sections Scrambled Eggs, Roll • Consommé Roast Turkey Mashed Potatoes Buttered Peas Cranberry Salad Butterscotch Sundae • Cream of Carrot Soup Sausage Cake Escalloped Corn Apple-Date Salad Chocolate Roll	**24** Orange Juice Soft Cooked Egg, Toast • Cream of Celery Soup Fried Ocean Perch O'Brien Potatoes Okra With Tomatoes Pineapple-Cabbage Salad Butterscotch Pudding • Julienne Vegetable Soup Macaroni au Gratin Buttered Broccoli Jellied Fruit Salad Green Gage Plums
25 Prunes Pancakes, Sirup • Beef Rice Soup Breaded Pork Cutlet Mashed Potatoes Spinach, Egg Slices Turnip Slaw Raspberry Sherbet • Oyster Stew Baked Noodles and Tomatoes au Gratin Buttered Peas Green Relishes Lemon Meringue Pudding	**26** Fresh Grapes Fried Egg, Toast • Pepper Pot Soup Braised Liver O'Brien Potatoes Baked Onions Orange and Grapefruit Salad Butterscotch Pudding • Cream of Spinach Soup Veal Stew With Biscuits Baked Squash Deviled Egg Salad Cubed Pineapple	**27** Banana Soft Cooked Egg, Roll • Tomato Juice Smothered Steak, Mushroom Sauce Baked Potato Buttered Brussels Sprouts Vegetable Salad Butter Pecan Ice Cream • Vegetable Soup Roast Pork Tenderloin Escalloped Sweet Potatoes Hearts of Lettuce Emperor Grapes	**28** Pineapple Juice Bacon, Toast • Beef Rice Soup Barbecued Chicken Baked Potato Corn on Cob Fruit Salad Angel Food Cake • Cream of Pea Soup Salmon Salad Potato Chips Buttered Spinach Raisin-Rice Pudding	**29** Grapefruit Sections Poached Egg on Toast • Vegtable Beef Soup Baked Halibut Creamed Potatoes Broccoli, Hollandaise Sauce Cottage Cheese Salad Baked Apple • Chicken Noodle Soup Ham à la King on Toast Buttered Beets Pineapple-Cheese Salad Coconut Pudding	**30** Orange Juice Scrambled Eggs, Muffin • Rice Soup Roast Beef, Gravy Mashed Potatoes Buttered Green Beans Lettuce Wedge, French Dressing Pumpkin Pie With Whipped Cream • Oxtail Soup Spaghetti With Meat Balls Buttered Asparagus Tips Sunshine Salad Sliced Apricots

Ready-to-eat or cooked cereals are offered on all breakfast menus.



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ARMOUR AND COMPANY Hotel and Institutions Department • General Offices, Chicago 9, Illinois

If you must move the walls

Metal Is Better Than Masonry

ALEXANDER BERESNIAKOFF
Architect, New York City

SPACE changes take place in hospitals as often as in any other type of building—possibly oftener. The easiest way of making such changes is by the use of metal partitions. This should be borne in mind not only when the changes are contemplated but also during the original planning of a hospital. Because they are simple to move, metal partitions lend themselves, as no other material does, to easy rearrangement for the extension or contraction of spaces at small cost and without waste.

To change a space enclosed by masonry partitions means the destruction of materials that were costly to erect in the first place and are costly

These four photographs represent some of the areas in which movable metal partitions are used to good advantage. In wards, the partitions may be either solid panels (above, left) or partly glazed (above, right) to admit more light.

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It waxes as it cleans!

REDUCES THE FREQUENCY OF REFINISHING

Sanax was developed to permit frequent cleaning of waxed floors *without washing away the finish* . . . and to eliminate waste in wax and labor. A neutral liquid soap with a wax base, *Sanax* not only quickly removes dirt, oil, and grease, but *leaves a thin film of wax.* In fact, regular use of *Sanax* to machine-scrub or damp-mop waxed floors *actually prolongs the life of the finish,* and thereby reduces refinishing costs on a year-to-year basis.

Like all *Finnell Fast-Acting Cleansers, Sanax* is specially designed for the greater speed of machine-scrubbing, and works as effectually in a *Combination Scrubber-Vac* as in a *Conventional Scrubber-Polisher.* And because *Sanax* is processed from pure vegetable oils, it's *safe for all floors.*

A 100 Series General-Purpose Finnell 11, 13, 15, 18"

Find out how you can simplify and reduce the cost of caring for waxed floors. *There's a Finnell Floor Specialist nearby* to help you choose the waxes and cleansers that are *exactly right for your needs. Finnell* makes a complete line, so you can depend on unbiased advice. In fact, *Finnell makes everything for floor care!* For consultation, demonstration, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1408 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

- **A mild liquid wax-soap for machine-scrubbing or damp-mopping waxed floors**
- **Leaves a lustrous anti-skid protective finish**
- **Highly concentrated . . . economical to use**

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything FINNELL for Floor Care

BRANCHES IN ALL PRINCIPAL CITIES

to replace in the new locations because of the services that must be provided through the various building trades involved. The work of these tradesmen not only affects expense but also causes delays. First the mason has to put up structural blocks; then it is the plasterer's turn, and after him the painter, each one, of course, with his own unavoidable mess. Such changes are very annoying to both patients and personnel because of the noise and dust during removal of the partitions and the odor of paint during erection of the new ones.

All this is avoided when metal partitions are used. Such partitions, if in place, can be easily removed from existing enclosures and relocated to form new enclosures with little waste of material and without disturbing noises and discomforting paint odors. Above all, this can be accomplished without delay and with a minimal expenditure of funds. In cases in which no existing enclosures have to be changed but new subdivisions of larger areas are required or new spaces have to be enclosed, metal partitions are the best material to be used.

Metal partitions can be used in almost any part of a hospital. They can be employed to divide wards and to form the examination and treatment cubicles of the admitting service and of the outpatient department. They are useful for separating waiting spaces from treatment spaces, for enclosing nurses' stations and administrative offices.

In spite of the "standard" widths and heights, metal partitions are flexible in either direction, and the spaces in which they are to be used do not have to be "tailor-made" to accommodate manufacturer's dimensions. For partitions are expandable, both lengthwise and in height, by the introduction of "filler" units, which do not detract from the over-all appearance of the partitions. In fact, the variety in panel size often enhances the general appearance.

In wards or other areas of the hospital metal partitions are particularly desirable because they provide an easy way to install required facilities for the treatment of patients. Electric conduits, oxygen and vacuum piping, lead protection against x-rays, plumbing and other facilities can all be accommodated within the standard 3 inch thickness of the partition. These facilities are readily accessible for repair or change by the removal of the base members of a partition or of an individual panel. Both can be replaced after the repairs or changes are made without injury to the partition.

Since they are only 3 inches thick, these partitions are space savers; no masonry partition used in a hospital is less than 5½ inches thick. When so many rooms in a hospital are to be divided or enclosed this saving in space can be calculated without resort to higher mathematics.

The flush surface of the metal partition presents no cleaning problem. The baked-on enamel surface has no projections of any kind to impede its being wiped down with a dry cloth or its being washed with soap and water to assure "hospital cleanliness." The finish comes in various colors to match existing wall colors or to create any desired color scheme.

The metal partitions on the market today are insulated to provide the quiet necessary in a hospital. They are available in a solid panel or glazed, the latter for admitting light when it is desirable for general visibility or for better observation when that is needed.

ADMINISTRATOR — SUPERVISOR — TEACHER —

The Housekeeper Is Three People

EMILY C. DEMING
Executive Housekeeper, Butterworth Hospital, Grand Rapids, Mich.

TO ORGANIZE a housekeeping department you don't begin with the housekeeper, for housekeeping and its organization are not an end in themselves—they are an integral part of the pulsating miracle we call a modern hospital.

A housekeeping department may be organized to meet one of four situations:

You may go into a new plant in the building process and set up what you hope will be the world's ideal installation, incorporating many of your own ideas and all of your practical experience.

You may go into an old hospital that has never had a housekeeping department per se, and organize one, in which case, the Lord help you.

You may go into a well organized, highly departmentalized hospital, in which there has always been a recognized housekeeping department. In this case, one of two things happens. In the first, you follow an intelligent woman who has done an excellent job, and even the most courteous of your fellow workers will have a nostalgic tone in their voices when they discuss the way Our Mrs. So and So did this or that. Or, you will follow an utterly incompetent person and bump up against all the problems inherent in a hospital that has a mild contempt for the department which has never delivered a proper job and for your own employes whose habits, practices and methods are bad.

You may expand an existing department to meet a new building project.

Condensed from a paper presented at the housekeeping section of the Upper Mid-West Hospital Conference, St. Paul, 1952.

No matter what the situation in which you are asked to organize a housekeeping department, you have one of the most challenging and exciting opportunities open to women today, and you begin, not with yourself, but with the community in which you live or intend to make your home. If you have lived for a long time in the area, you will have the necessary background and understanding of the particular needs of your community. If you are a newcomer, especially in a region of our vast country that is strange to you, concentrate all of your efforts, exercise all of your abilities to their utmost, make every pore a living, breathing, fact-absorbing unit. Be as nearly as possible a sponge, for you will need to absorb the habit of thinking, the pattern of living, the food and bathing habits; you will need to know these people as they have always lived before you can hope to keep house for them and, if necessary, change some of their habit patterns.

If you move into a community in which a sheet is a novelty and two sheets a conundrum, you needn't be too surprised if some of your patients put their mattresses on the floor or even curl up in a comfortable corner, happy with only a blanket.

If a standard practice of your hospital is an admission de-lousing booth for patients, don't be disturbed if cockroaches, ants, bed bugs or pediculi fail to engender your own state of hysteria or, in fact, even mild discomfort in your patients.

And remember, too, it is from the same group your patients come that your staff will come. If you live in a solid Dutch community where the citizens' ancestors traditionally scrubbed their streets, teaching cleanliness and maintaining it is not too much of a problem.

If, however, many of them have slipped in, say across the Mexican border with only the filthy rags on their backs, training the staff to the niceties of aseptic housekeeping is a horse of a far different color.

Study your community, be sure you understand exactly what housekeeping for your particular area involves. You may work for an administrator who thinks that housekeeping is merely the function of cleanliness, in which case, pack quickly and take the first train out of town. You may work for an administrator who feels that housekeeping encompasses many of the rewarding functions of a modern hospital. In this case, dig in and work. Be sure not only of what your administrator expects, but how he expects you to achieve the end results he wants.

If you work in a state institution where patient labor is used, such labor may be considered of therapeutic value and you may sit up nights devising hand methods of performing normal machine operations. One of the hardest jobs I ever did was to set up standards and cleaning methods for a county juvenile home, housing all ages up to 18 years. It is possible that labor is less costly and more beneficial than machines. Usually, however, your problem is to divide the budget you are to be given into the best working proportion between machines and personnel. Incidentally, try to find out exactly what your budget will be. There is nothing more aggravating than never being

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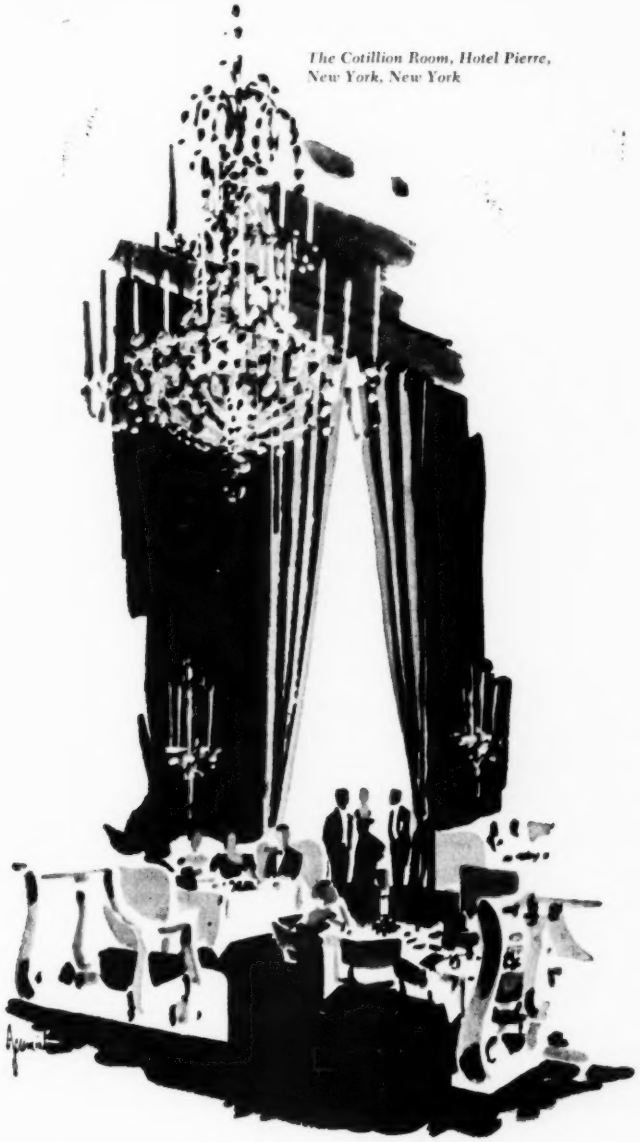

The Cotillion Room, Hotel Pierre, New York, New York

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and at no increase in price . . .
table napery woven
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- Smoother, more luxurious texture
- Finer yet stronger fabric
- Longer life, greater resistance to wear
- Handsomer looks, sustained through countless launderings
- Greater economy, with fewer replacements needed

Simtex napery stays fresh longer, too, thanks to Simtex exclusive permanent finish.

Simtex MILLS, DIVISION OF SIMMONS CO., 40 WORTH STREET, NEW YORK 13, N. Y.

given a specific budget for your department, yet always being chided, no matter how much or how little you spend. And nothing is more rewarding than having been given a conservative budget and producing more than the planned results from it.

In a government installation, you may find yourself, your department, and every piece of equipment you will use for the 12 months all neatly printed out so that all who can, may read. As a result, you run into some amusing situations: In making first rounds of a county institution with the administrator, we had progressed to the hog ranch, which, believe it or not, was an integral part of the hospital (we ate the hogs, the hogs ate the garbage, we ate the hogs, this can go on forever) and became repulsive only when it became necessary for the housekeeper to go down and check up on the garbage cookers and the can washers. As we met the ranch foreman, and I was properly introduced, the response was this: "Oh yeah, I seen you in this year's budget, whatcha going to do to earn that kind of money?"

WHAT THE JOB IS

Now let's get down to brass tacks and begin to spell out the actual job. You, the housekeeper, will be the administrative head of the department, a supervisor and a teacher. Within these three broad classifications your other functions can be outlined. As an administrative department head, you will decide what equipment you will need, what type and size machines are best suited to your needs, what supplies are most economically used, and how many persons it will take to run the department.

If you are fortunate enough to be organizing a new department and can control the total purchase of machines, rejoice! Most of us are burdened with a heterogeneous collection of equipment, necessitating our carrying multiple sizes and types of parts, as, for instance, bassine, tampico and palmetto brushes for perhaps three separate makes of machines.

Remember that every additional size and type of machine and equipment you carry predicates a certain number of feet of storage space for parts and supplies. In all of your thinking, in all of your planning, make a concerted effort to minimize types, styles, sizes in any and every item that you must stock. For instance, you need a small dust mop for bedroom work by the maid, you need a very large dust mop for corridor work. It is questionable whether you need an intermediate size or sizes.

Analyze your own plant, check your corridor width, know how many times the houseman must walk back and forth the length of the corridor to dust it. If the proper size push broom or dust mop will save once the length of each corridor of your plant each time that corridor is cleaned, and you take the trouble to figure up the man-hours saved per year, it will flabbergast you. And each piece of equipment, each push broom, mop, hand duster, gong brush, scrubbing machine, mop pail, wall-washing machine — everything that you use — should be chosen for the specific purpose of daily use, its ease of maintenance, and cost of replacement.

Above all, remember that you must teach illiterate or semiliterate staff to use each and every piece of equipment you buy. The fewer your purchases, the simpler the operation, and the more time employes can spend in using them rather than being confused by them. The slickest salesman with the newest gadget on the market may have an excellent talking and selling point, but if the gimmick you buy takes 20 minutes to get into operation because of its complexity, your purchase is a pretty stupid one. The importance of the type and quality of equipment can't be emphasized too much. The ratio between equipment, supplies and personnel in cost is, roughly, one to 10. Therefore, if you are to conserve personnel, you must expend thought, research and consideration before you buy so much as one 12 inch wet mop.

Your choice of personnel, together with your standards, teaching methods and supervision, will control the quality of work your department produces. Many of your staff come from the least protected, least articulate group, the so-called bottom of the barrel. Those of us who must do a job using this group of people know many who are warm and kindly, generous of the little they have, pathetically eager to go beyond the line of duty and to have the gift recognized for what it is, the gift of self. We should thank the Lord there are people who are willing and able to mop our corridors, to empty our garbage cans, to burn our filthy trash, to fold hot sheets from the flatwork ironer. And we should take the time to let these people know that they are just as essential to the total picture, just as much a part of total patient care as is the biggest name surgeon on the staff.

More often than not, your secretary is essentially your right hand. Choose wisely and well, because while she may not leave the office twice a day, her intelligence and quick thinking can reach every corner of the plant, every person working in it. In one sense, she will have more contacts than either you or your assistant.

Your assistant, of course, is an essential person. She must have many of the qualifications you yourself possess. She should be training for an executive job and she should never have been ruled out of the National Executive Housekeepers' Association.* If you are adequate for the job you are doing, you needn't be afraid of the strength of such a woman. If you are weak enough to fear her capabilities, then you are in no sense of administrative caliber.

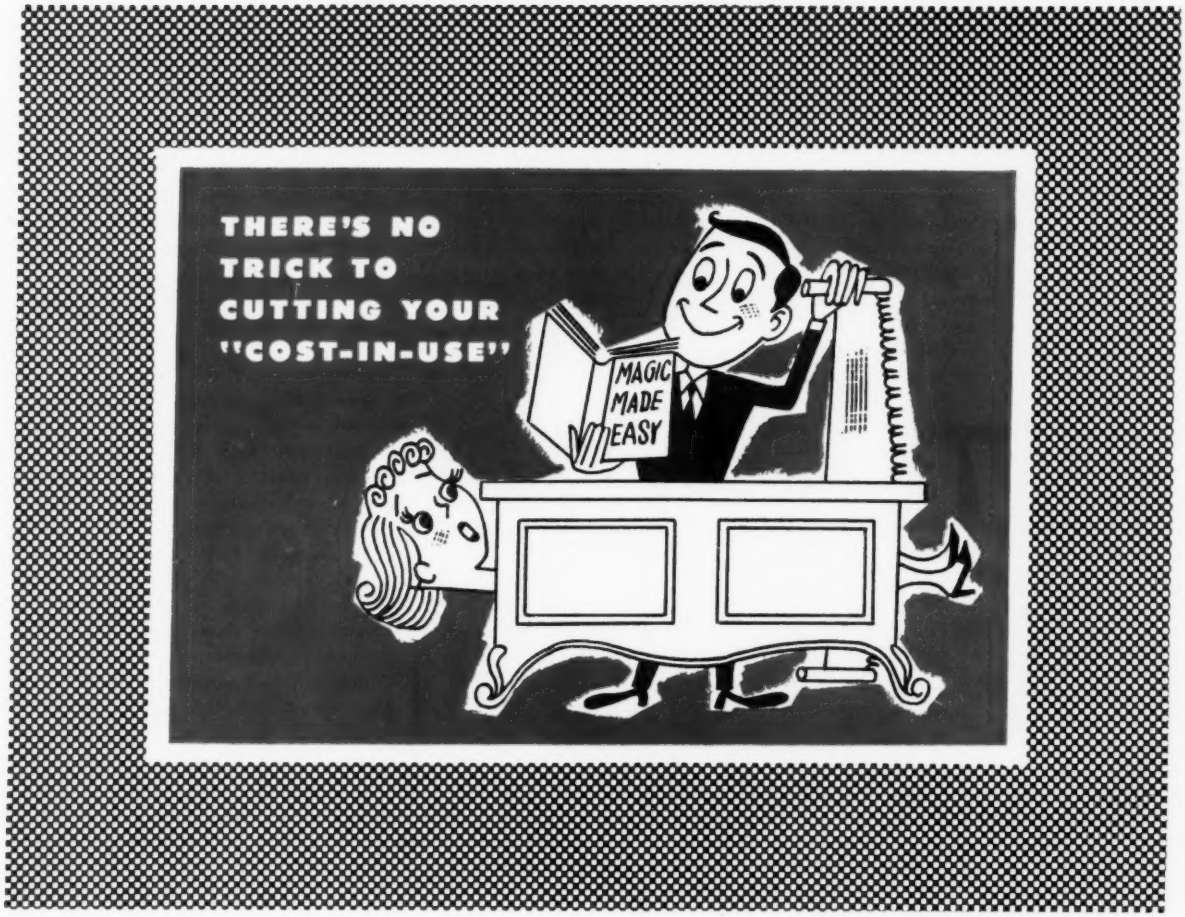
CHOOSE SUPERVISORS WISELY

Your next consideration is your floor supervisors, your head houseman, shop foremen, laundry manager and chief seamstress. Your supervisors should be chosen with such wisdom and trained with such care and patience that they can logically expect to move up in the assistancies as they become vacant.

The head houseman is an extremely important person. He can often actually make or break your budget. For in a small hospital he supervises or does all of the diversified tasks that in the large plant are cared for by assistants or individual shop foremen.

The head painter, the wall-washing foreman, the upholsterer, the plumber, the shade and blind shop man, the electrician, the head gardener, the carpenter, the maintenance shop man, the wheel shop and key shop men, any and all of these may at some time in your career be classified as housekeeping personnel. To hire men to handle the jobs properly means that you must have sound basic knowledge of the work performed by all of these staff divisions. Not only must you know something about each of these shops, but you must have some understanding of materials, supplies and

*Since this article was prepared, assistant housekeepers have been restored to associate membership in the association.—ED.



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equipment necessary for their operation.

If the laundry comes under your department, as it does in many hospitals, even large ones, a competent manager or supervising washman, depending upon the size of your operation, is essential. Even the small hospital has many thousands of dollars invested in the physical equipment of its laundry plant and many more thousands invested in linen inventory. Almost nowhere in the plant, except perhaps in food service, can you cause patient discomfort so quickly, and curtail the proper nursing function so effectively, as you can by inadequate laundry service. It's a big field, full of problems involving constant study and infinite attention to detail.

Many is the housekeeper who has found that running the laundry ran her housekeeping department into the ground because she was inadequately prepared to cope with these chemical and technical problems.

The sewing room with its endless mending and fabrication of special items can contribute materially to an efficient department and a balanced budget for the hospital.

The type of machines used, *i.e.* oscillating two-thread, three-thread edgers, darners, electric cutters, the placement of machines for work flow, simple concise cutting charts, the well organized pattern file, good records, and supervision are all essential.

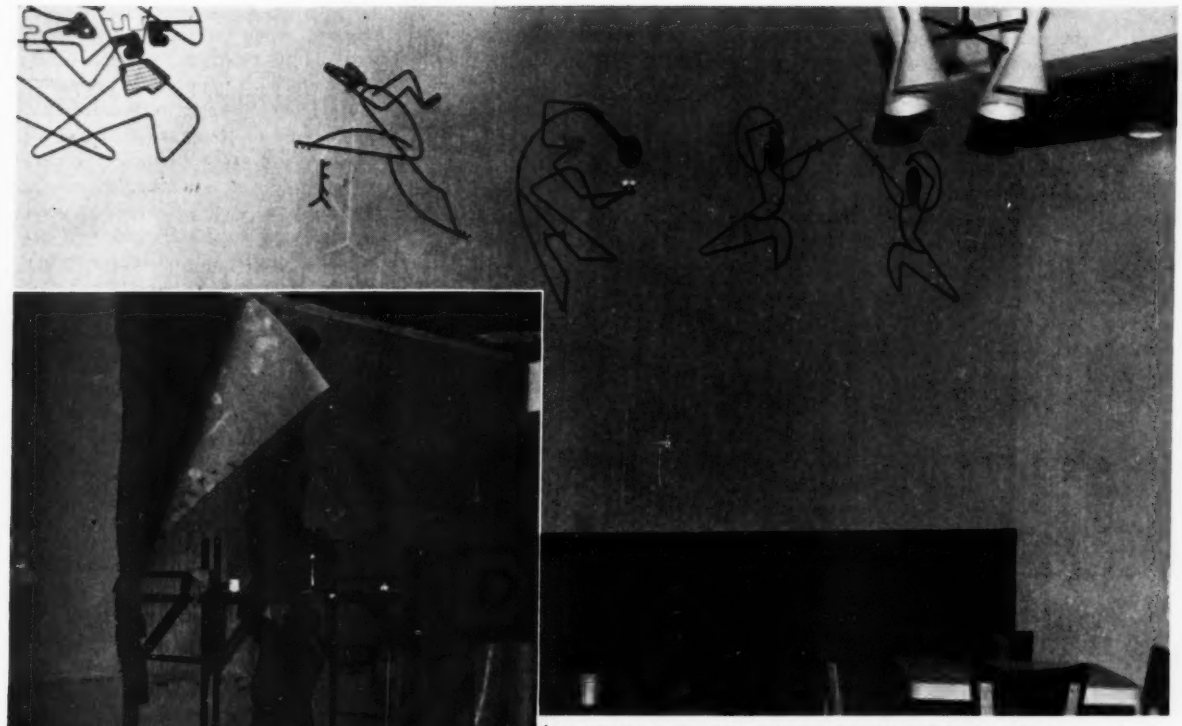
While the purchasing agent in most plants does the actual buying today, the intelligent housekeeper, by guiding the choice and quality of fabrics purchased, whether by yardage or finished item, can make almost dramatic contribution to budget conservation. Look with a jaundiced eye at that little item "f.o.b. mill" or "f.o.b. delivery point." If yours is not a tax exempt hospital, you may be astonished at the budgetary saving possible by choosing f.o.b. mill delivery because you pay the tax only on actual purchase (freight being a separate item) rather than on f.o.b. plant delivery, which actually includes taxation on transportation. If you work on the West Coast and are taking mill delivery, for instance, from a Carolina factory, check the cost of water transportation *versus* rail. The net saving may buy you hundreds of yards of fabric.

Then, too, there is the important item of 2 per cent for payment within 10 days. Never let it slip! Let your records be so accurate that you know how much of each given weight and width of yardage or how many of each purchased item you will use within a twelve month. Always check fabric purchases for price break. An extra six dozen items, an extra 500 yards may actually put an order on your shelf at less cost because of the larger order.

The policies of various institutions will, of course, control your buying practices within any given hospital, but the minimum for good fabric purchasing in an average sized plant will be quarterly inventory with the option of a better price break at the semiannual or annual inventory level.

Another controlling factor in all of your purchases, not just for sewing needs, is the amount of storage space allocated to stock room and to your own department.

Even if your particular hospital does not have cost accounting, you will be wise to reexamine your item cost, at least annually. Frequently a swing from manufacture in the department to purchase of manufactured



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. . . Bolta-Wall is a washable wall covering of extraordinary beauty — beauty that will last indefinitely because Bolta-Wall has outstanding resistance to scuffing, staining and fading. It will not crack or peel and is fire-retardant. Maintenance costs are reduced to a minimum, replacement and repair are virtually eliminated.

. . . Bolta-Wall goes on any dry wall construction *fast* — needs no plaster backing. The Waldorf used low-cost gypsum sheeting as a base for this 1500 sq. ft. installation . . . no waiting for plaster to dry. Carpenters and other trades were able to work simultaneously because the application of Bolta-Wall requires small space and moves along quickly. Remodeling time was cut by weeks!

. . . Bolta-Wall provides a new, distinctive look in any one of 4 dramatic patterns and in combinations. Blends well with other wall materials. The Waldorf chose 3-dimensional Bamboo, available in several pastel tones. Your customers may prefer the rich Mahogany woodgrain pattern, distinguished Leathergrain or the enchanting new Georama Line of soft, modern pastels.

Comparable durability and elegance cannot be found in any wall covering without paying up to 30% more than the cost of Bolta-Wall. Available by the yard and in 8" tiles. Write for free samples and specifications today, Box 546.

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goods, as the market for yardage and fabrication fluctuates, can substantially affect the budget.

As a department head, you must coordinate all of your services with the intricate functions of other departments of the hospital, working always to the one goal of excellent patient care. You must establish and maintain good interdepartmental relationships. You must be willing to make many decisions and be able to abide by the outcome, whether they are good or occasionally bad. You must initiate simple, concise, adequate office records: usually some form of perpetual inventory is most effective. But, whatever the method, it should be economical of time and productive of accurate information.

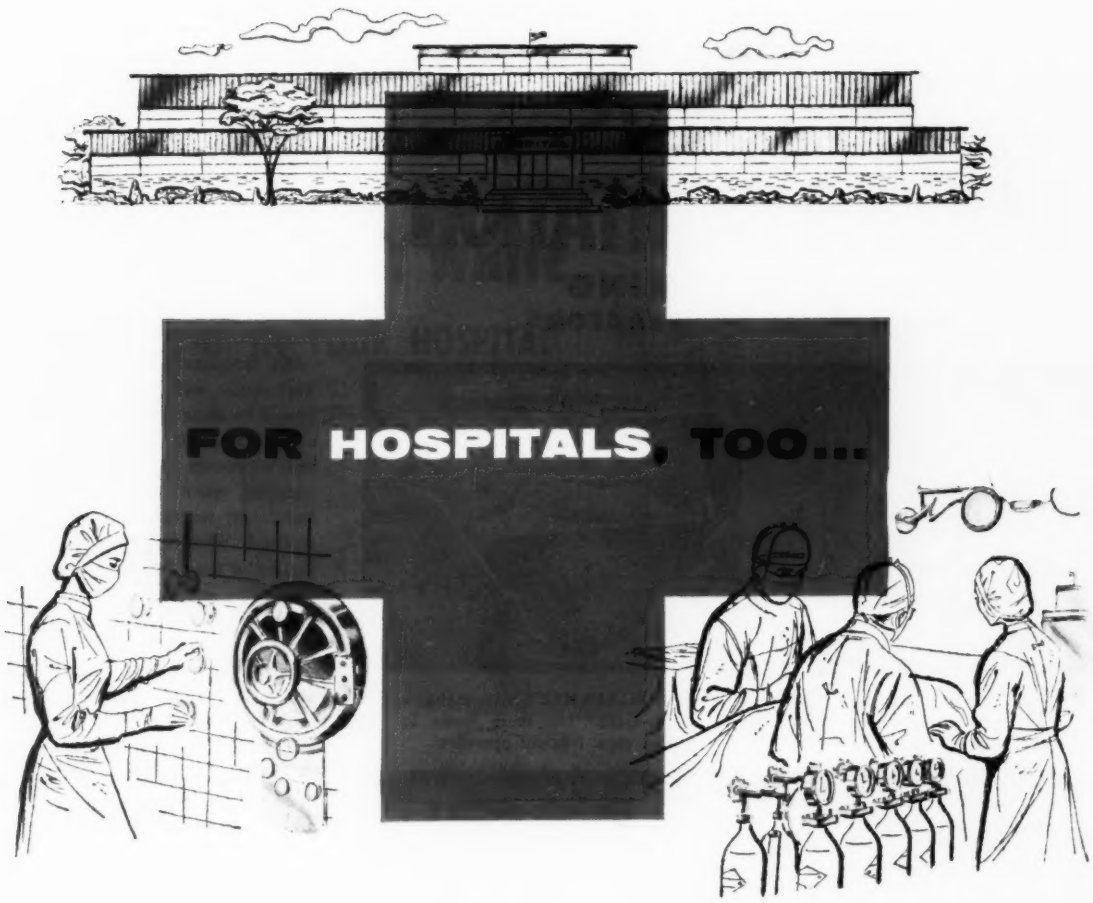
As a teacher, your job is never-ending, for you should work with every person in the plant and in many instances you may reach out into the community to promote better public relations through a better understanding of the intricate function of a hospital, of the many hidden jobs that patient, doctor and community never dream of and fail to understand the need for, when the Community Chest or building program or some other public appeal for support is necessary.

You are, of course, responsible for the training of your own staff and on the quality of your training, the persistence of your training, the even, constant pressure of insistence on good methods and good standards will depend the quality of your department's service. You must be willing and able to teach the lay staff of the entire plant. You must also be able to teach the professional staff, students, staff nurses, interns, doctors. The coordination of the modern hospital is such that every person in it must have some knowledge of the things that can and cannot be accomplished by housekeeping.

A trend is developing for housekeeping to take over all floor functions, except actual nursing technic. This means, for instance, that when a patient is dismissed, housekeeping enters the picture and nursing does not function again until a new patient is in bed in a perfectly set up unit—an interesting trend and one that should lessen basic hospital cost. It will take the patience of Job, the balance of a tight-rope walker, and the disposition of a saint for the average housekeeper in the average hospital to work in such close harmony with the average nursing department. But, with the ever increasing cost of so-called nursing personnel, the average housekeeper with consistent training and supervision could, I think, produce a greater volume of work for less cost.

Supervision is of paramount importance. It serves no good purpose for you to spend an hour teaching and demonstrating as basic a technic, say, as using a push broom, unless every time you or any one of your supervisors sees an employe using a push broom in any but the method taught, you immediately stop that person and take the time to remind him of the proper technic and to watch long enough to see that he is actually using it before you go on to the next task.

It does no good to say we dust the window sill every Wednesday unless you run your finger over the window sill on Wednesday or at least on Thursday morning. If your program is to dust venetian blinds on Tuesday, then on Tuesday check up, on the top half as well as the bottom half, of your venetian blinds. If brass is to be kept polished, don't ignore the un-



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polished metal ring around the hall call light. Don't expect your staff to care enough to do any job on the program unless you care enough to see that the job is supervised, noticed and commented on for better or worse. Nobody polishes brass for the sheer joy of polishing brass, but a well deserved commendatory exclamation, preferably so it can be heard by at least one other person, is a stimulus one can't afford to ignore. Conversely, if the criticism is adverse, always make it in private.

As frequently as possible, have a conference with each employe. This should be done quarterly if your schedule permits of it. Certainly, it should be held whenever an employe is doing outstanding work or is failing to meet standards; whenever an anniversary is reached, whenever a step increase is earned or must be withheld. Give each one the satisfaction of a personal evaluation, stressing the good points first. Those that need improvement should be emphasized, but try not to make them the only thing emphasized and don't err on the side of pushing supervision too hard.

We have a wonderful maid who has worked for me for years. An excellent new supervisor was taking on her first 20 bed ward for our standard procedure of wall-washing, painting, complete cleaning and reactivation to service between 7 a.m. and 4 p.m. When I dashed onto the floor, Liddie was in a state of collapse against the wall, and to my quick inquiry, "for goodness sake, Liddie, what's the matter, are you sick?" she answered in a wail of utter distress, "Miss Deming, dat Miss Johnson, she taken down the curtains, she moving the chairs, she pushing the beds, she going up and down so fast, Miss Deming, that Miss Johnson, she pure violent, she is." Let your supervision be good but do let it stop short of being violent.

There are a hundred other facets of organizing and operating a housekeeping department: responsibility for safety practices, fire protection, linen inventories, the purchase of furnishings of all kinds, the fascinating rôle of decorator. If you have the heart and courage, the imagination and stamina to stand the pace that knows no hours, no days of the week, no planned holidays that are not subject to emergency cancellation, you can make housekeeping in a hospital the most rewarding experience open to any woman—anywhere.

Methods Studies Aim at Better Design

(*Continued From Page 73*)

MR. CLARK: As a matter of fact, we've incorporated into the Greater Cleveland Fund a statement to the effect that all hospitals receiving monies from that "pooled" money must have their plans approved by this reviewing committee.

MR. JONES: Are you bringing the department heads into these reviews as well as administrators?

DR. SUTTON: Yes, in some cases.

DR. CARTER: We've tried to keep the group relatively small, but the men who have worked here as assistants have been sitting in on the planning.

MR. JONES: Sometimes administrators and their principal assistants are a little too inclined to study plans and make the decisions on their own, without bringing in the affected department heads, who have a more intimate knowledge of the thing.

DR. SUTTON: There is undoubtedly a greater enthusiasm and willingness to make the department work if your department heads have a part in planning — with just one qualification. When you have a turnover in department heads in the course of building, then the new department head coming in may want to revise things completely, and your plans are already crystallized and you're unable to make changes.

DEPARTMENT HEADS INCLUDED

DR. CARTER: We've made a practice here of bringing in department heads and anyone else who had an interest in what we were doing. Now one reason why this nurses' communication system of ours has gone over is because of the invitations to the nursing group to take part in the original planning. Without participation by the people who will use a system, you will have trouble.

MR. FREDERICK: I'd like to make a statement here from our first article, which is one of the foundations for a methods program. "The accumulated knowledge in the minds of hospital personnel represents a vast wealth of material which, if properly directed and organized, can serve as a solid foundation for unlimited improvement in the detailed operation of any hospital." One thing we tried to do on this methods program was to question the individuals working with the various phases of operations we're analyzing.

MR. JONES: You're trying to bring out everything those department heads know.

MR. FREDERICK: Department heads are only part of it. We're interested in what the person who actually does the job thinks about it and how he thinks it could be improved, and you'd be surprised at the number of excellent recommendations that come from the person who's doing the job.

MR. JONES: For instance, you're going to work on the design of a nursing unit station, or a utility room, or anything on a nursing unit. There are many graduate nurses or student nurses or practical nurses or maybe orderlies, who have some ideas. What you are trying to do, I take it, is to capture the ideas of all the people who really do the work.

MR. SHOOS: We want to get as much as we can out of them, because they're the people who are on the job every day, and they have to utilize whatever procedures we produce.

DR. CARTER: You must remember that function follows design. That is, you should build the place so that the jobs can be done in the easiest possible fashion. As you design your hospital, it is going to function along the line you have designed. It's bound to, unless the design is so terrible that the employes can't possibly do it. I think that brings in this idea of designing in the first place in such a way that everybody will want to do it the way it was designed to work.

MR. JONES: Of course, the work that people like Earl Frederick are doing in methods engineering will greatly affect that design, so what we really should be doing is finding out the function, studying it, and then designing to suit the function, and not the reverse.

MR. FREDERICK: In running a methods analysis, whether it is the redesign of a utility room or the redesign of a whole area, such as an emergency room or a hospital, we have to accumulate facts about what is being done at present. One of the best ways to accumulate the facts is to interview the employes and sound out their opinions on various operations. The methods program offers a clearing point where ideas can be brought together and mulled over for the over-all best interests of the hospital operation, and where we can come up with some recommendations which will improve patient care and reduce costs.

MR. JONES: I was very much impressed by those studies you made in the dishwashing room and the laundry, which resulted in the first two articles you wrote for us. Had such studies been made before those rooms were designed, they would have materially affected the layout and design of those departments.

SIMPLIFY TRANSPORTATION

MR. FREDERICK: As Dr. Carter pointed out before, the thing we have to eliminate in this hospital is transportation, and in the organized planning of the layout of any work area the transportation will certainly be affected.

DR. CARTER: We have to remember all the time that design originates with function, and you get function from the department heads and others all the way along the line. Once the design is made, function must follow design.

MR. SHOOS: There's another angle of this organized common sense program we have here which I've found very interesting and useful. As you get large in scope and size and so on, there's a tendency to get pretty rigidly departmentalized, and you can trace it right down. The housekeeping department runs in its channel, the nursing department runs in its channel, and the dietary department in its channel. There's a lack of communication which develops at the local level, and that's at the patient level.

You can bring it right down to the point where someone drops something on the floor. Who's going to pick it up? Is it a job for a nursing aide or a housekeeping maid? And do you

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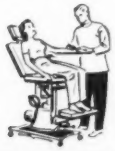

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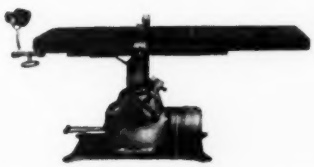

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have to have an executive order from each of those two departments before somebody does something about it? Now in our nursing study of the activities of the head nurse, and we tried to include everything that would happen in a nursing station, I think we were able to demonstrate to those departments that that was one of their problems. If you just sat down and said, "Well, now you're not cooperating," you wouldn't get any place. We were able, through a rather simple study, to bring forth real cooperative thinking and in a semiscientific way to bring to these people the fact that they weren't coordinating their efforts properly. One way we got around it was the conference method, where we developed the problem for them out of facts and then presented it to them. You'd be surprised how they'll jump to it and work it out themselves.

MR. JONES: You've brought up what, in my mind, is one of the greatest advantages of this business of organized common sense and methods engineering. You are unquestionably affecting the morale of every employe in the hospital, because you're making their jobs easier and pleasanter. You are helping people from different departments to get to know each other. They are beginning to understand each other's problems. So it seems to me that methods engineering gets right into the middle of your personnel relations and the whole morale of your hospital.

MR. FREDERICK: I'd like to add that you are providing for the employe a chance to express an opinion to someone who is not responsible for the over-all operation of the hospital, someone who can listen to his problems and make recommendations to the people responsible. In a way it provides a medium of communication.

DR. CARTER: It eliminates a lot of the frustration that many employes feel because their ideas are never picked up and used.

MR. JONES: I talked earlier about our ability to save 5 per cent, or 10 per cent or 3 per cent on the over-all patient's bill with these methods. It seems to me that equally, or even more, important is the result of this methods engineering work in cementing and correlating the thinking of people in various departments, so that they all begin to see what part they play on the team, how their actions affect everybody else on the team, and how, in the long run, what everybody thinks and does affects the person with whom we are primarily concerned, the patient.

MR. CLARK: Well, if we can do that for our patients it isn't only a saving of the 3 or 5 per cent on their time spent in the hospital. We're not talking so much of dollars, but you'll save millions of dollars from the utilization of your buildings to the point that you don't have to construct a lot more buildings than you would otherwise.

MR. JONES: You get more patients using the beds you have available; that's the important thing.

DR. CARTER: We're getting dangerously close to being overhospitalized in a few places in this country, I think, and simply because we aren't paying enough attention to the shorter stay and emphasizing its importance and then analyzing the results of the shorter stay.

MR. JONES: You are doing one other thing. You're getting every staff doctor interested in the program of studying hospital operation. And again I say that without the full cooperation of the doctors, we never can accomplish the results we're going after.

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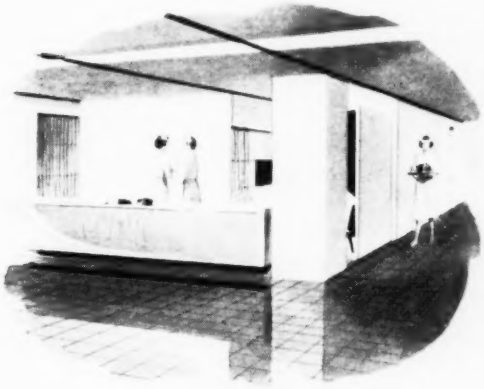

décor. Here is a product that fights grease, defies alkali and stubbornly resists acids — a product especially suited for the problem floor areas of laboratories, X-ray rooms, diet kitchens and food serving areas. And finally Vina-Lux is tough and flexible — will stand up under the abuse of rolling equipment and concentrated foot traffic.

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AZROCK FLOORING PRODUCTS

Why Surgeons Support Accreditation

(*Continued From Page 62*)

and the patient lost several days at school. After examination and evaluation, I advised appendectomy even though I was in considerable doubt that appendicitis was responsible. Certainly, however, the dictates of good surgical judgment indicated operation. The referring doctor accepted the advice but asked that I transfer the patient from her present hospital, which had an active tissue committee, to another hospital in which such a committee had not been established.

"TROUBLE" WITH COMMITTEE

Last week a surgeon called me from a small city in Minnesota, described the history and findings of a patient who had a long story of peptic ulcer and who, though he had none of the serious complications of ulcer, was completely "fed up" with his ineffective enslavement to an ulcer regime. Asked whether I would consider surgery indicated, I stated that, in my opinion, intractability when stubborn enough is a relative indication. The surgeon thanked me, said he had believed so from the first, but was having trouble with his tissue committee, which would accept only absolute indications.

The first example represents lack of understanding on the part of the staff man as to the function of the tissue committee, and the second, lack of understanding on the part of the tissue committee as to its function and relationship to the staff.

It will take time, patience and experience before we shall make such committees work purposefully and profitably for all concerned.

There are yet other topics that bear mightily on my assignment.

Obviously, fee-splitting and ghost surgery must be eliminated by any staff that is striving conscientiously to better its surgical services. Ghost surgery is impossible without the connivance or inexcusable apathy of a staff and hospital administration. I am convinced that ghost surgery is either rare or nonexistent in this part of the country.

Fee-splitting and surgical staff betterment are mutually incompatible. I am referring here to that most dishonest and reprehensible form of splitting in which a secret division of fees takes place unbeknownst to the patient. No one defends this type of practice. There is, however, a very real need for medicine as a whole to define fee-splitting and to clarify the ethical financial relationship between doctors who are participating in the care of a patient. To adopt a too rigid definition is to drive a wedge between general practitioner and surgeon and to discourage the use of surgical consultation or reference. To adopt too loose a definition is to permit a financial motivation for reference of surgical cases.

Again, I believe that using the definition of a "secret division of fees unbeknownst to the patient," there is little fee-splitting in my part of the country and I hope in yours.

CAN ELIMINATE BAD PRACTICES

Again I believe that any staff with the support of its board or even any board alone could, if it were so minded, eliminate such practices or so limit their occurrence as to make them nonexistent and nonobstructive to a staff's effort at self-betterment.

There are many phases to the problem of improving surgical practice at hospital staff level but space will not permit me to discuss them. I would have liked to consider improvement in anesthesia, wider consultation, and recovery rooms, but have chosen to touch on some subjects I consider more important.

I should like to point out again that in giving voice to the foregoing opinions, I am speaking as an individual surgeon, but I hope and believe most sincerely that similar views are widely held in our profession.

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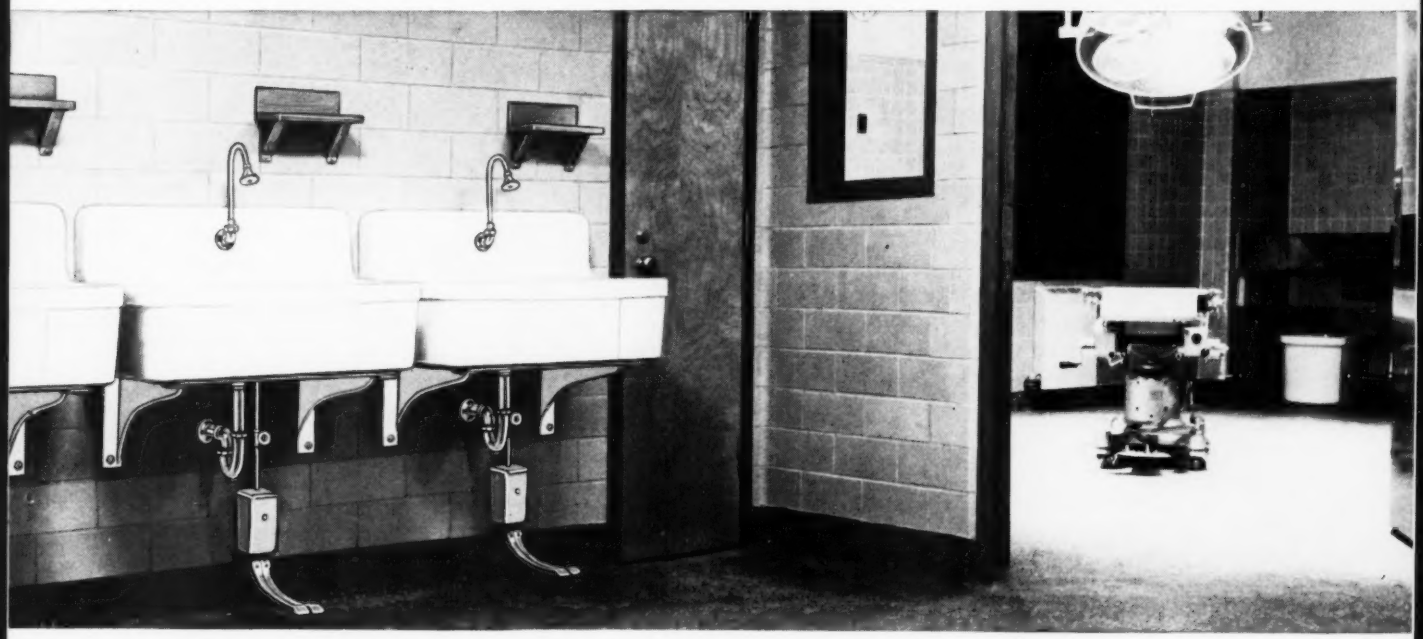

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NEWS DIGEST

Hospital-Employed Doctors in Colorado Face Revocation of Licenses . . . Urges Uniform Standards for Nursing Homes . . . Architects and Administrators Discuss Design Trends . . . Medical Technologists Seek Recruits . . . A.H.A. Award

Colorado Hospitals Fight Revocation of Licenses of Hospital-Employed M.D.'s

DENVER.—Hospital leaders in Colorado were moving last month to prevent the State Board of Medical Examiners from revoking licenses of hospital-employed physicians, following a ruling by the state attorney general that hospitals employing physicians are illegally engaged in the corporate practice of medicine and the physicians are guilty of unprofessional conduct.

FOLLOWS OTHER RULINGS

The attorney general's opinion closely followed those previously issued by state attorney generals in Iowa and Ohio on the same questions.

The Colorado Hospital Association was also reported to be organizing an effort to seek legislative action aimed at amending that part of the state medical practice act affecting employment of physicians by hospitals.

In reply to specific questions presented by Dr. George R. Buck, president of the State Board of Medical Examiners, Attorney General Duke W. Dunbar on May 19 issued an opinion interpreting the medical practice act as it relates to hospital practice. The opinion read in part as follows:

"1. A hospital corporation which employs licensed doctors specializing in pathology and radiology to perform medical services as services of the hospital is engaged in the practice of medicine; such practice by a corporation is illegal since a corporation may not be licensed so to practice.

"2. Such employment by the licentiate is expressly made an act of unprofessional conduct in violation . . . of the Medical Practice Act.

"3. The legislature has not seen fit to invest nonprofit corporations with any express power to practice medicine or offer medical services as services of the corporation. Nonprofit corporations stand on the same footing as for-profit corporations, so far as their ability to be licensed to practice medicine is concerned. It is, therefore, concluded that, where nonprofit corporations perform acts constituting the practice of medicine as defined by the Medical Practice Act they are subject to the same penalties as are provided for illegal practice by any other unlicensed person or corporation.

"4. Sec. 17 (m) of the Medical Practice Act is clear and unambiguous, and susceptible of only one meaning: That no licentiate of the Board of Medical Examiners may practice medicine as the employe of any unlicensed person of any corporation except for the purpose of examining and treating employes of such person or corporation. It is impossible to read any exception into the plain words used by the legislature. It is concluded that such a licentiate would be practicing in violation of the Medical Practice Act."

A.H.A. AWARD OF MERIT

George Bugbee, who served as executive director of the American Hospital Association from 1943 until he resigned last May to become president of the Health Information Foundation, will receive the association's 1954 award of merit.

Council Urges Amendment of New Standards for Private Nursing Homes

NEW YORK. — Uniform regulation of private nursing homes is needed, in the opinion of the Welfare and Health Council of New York City. The council suggested that the new code of the New York City Department of Hospitals, which sets higher standards for nursing homes established after July 1 of this year, be amended to provide for uniform regulation of all homes within a period of three years.

"As it now stands the proposed code, by permitting nursing homes licensed before July 1, 1954, to operate for an indefinite period at standards substantially below the nursing homes that will be licensed after that date, will actually lead to the establishment of two sets of standards," it was explained. "The council suggests that the licensing agency establish a time schedule for the correction of violations which endanger the personal safety and health of patients."

If they are acted upon favorably, officials stated, the recommendations of the Welfare and Health Council would require the 92 licensed nursing homes in the city to meet the requirements of the revised code by July 1, 1957.

New Officers Named by Personnel Group

NEW YORK.—The Association of Hospital Personnel Executives has announced as its president for 1954-55 Jack Charlé, who is director of personnel at Beth-El Hospital, Brooklyn, N.Y. Mr. Charlé served as vice president for the past year and succeeds Annette Auld Kaicher. Other officers named are: vice president and treasurer, Harold Korolenko, Veterans Administration Hospital, Brooklyn, N.Y.; secretary, Sister Catherine Marie, Mary Immaculate Hospital, Jamaica, N.Y.

NEWS...

Architects and Administrators Discuss Design Trends at A.I.A. Meeting

BOSTON.—Interhospital cooperation on a regional basis, with smaller hospitals sharing services and facilities based at a larger, central hospital, will be practiced increasingly in years to come, Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital, New Haven, Conn., declared at a seminar on hospital design trends during the 86th annual convention of the American Institute of Architects here last month.

Dr. Snoke also asserted:

1. That the architect's first job is to "pin down" the owner or hospital group as to precisely what facilities are needed.

2. That the declared needs must be fully justified by facts.

3. That the architect and hospital consultant must get down to the department head level for detailed, expert opinion on functional needs and design requirements.

4. That today's shorter hospital stay and higher utilization mean more employes per patient and hence more locker room, restroom, washroom and other facilities for employe use.

In a paper prepared for the seminar, Vincent G. Kling, Philadelphia architect, urged better and more detailed planning for expansion and conversion of hospital facilities. In addition, Mr. Kling said, only one out of 10 hospitals anticipates the demand for automobile parking space.

The hospital of the future may well have three distinct types of inpatient facility, Mr. Kling said. "The first will be similar to a hotel, where admissions and patients undergoing routine survey can have attractive bedrooms without paying the high tariff associated with acute nursing areas for acute medical and surgical patients," he explained. "The second area might be what we know as the nursing unit, typical of most of our hospitals today, that will continue to serve the acutely ill. The third area, which will need less intensive nursing service, would be for chronically ill and geriatric patients.

"Such a plan would increase the pleasantries of the hospital's bedroom areas and because only the acutely ill would pay for intensive nursing service, certainly the chronically ill and the survey patient could be housed and spaced with much less costly equipment. Such a system might well be the answer to the high cost of hospital construction and patient service."

Marshall Shaffer, chief architect of the Hospital Facilities Division, U.S. Public Health Service, was moderator for the discussion of hospital design trends. In a statement presented to the convention, the A.I.A. board described the administration of the Hill-Burton Act by the Division of Hospital Facilities as "an outstanding example of how cooperation between a federal agency and private practice may be satisfactorily achieved." The board statement mentioned specifically the satisfactory relationship between a government agency and the private practice of the architectural profession exemplified in Mr. Shaffer's office, which, it said, "has come to be regarded as a necessity as well as an assistance, a guide and a friend."

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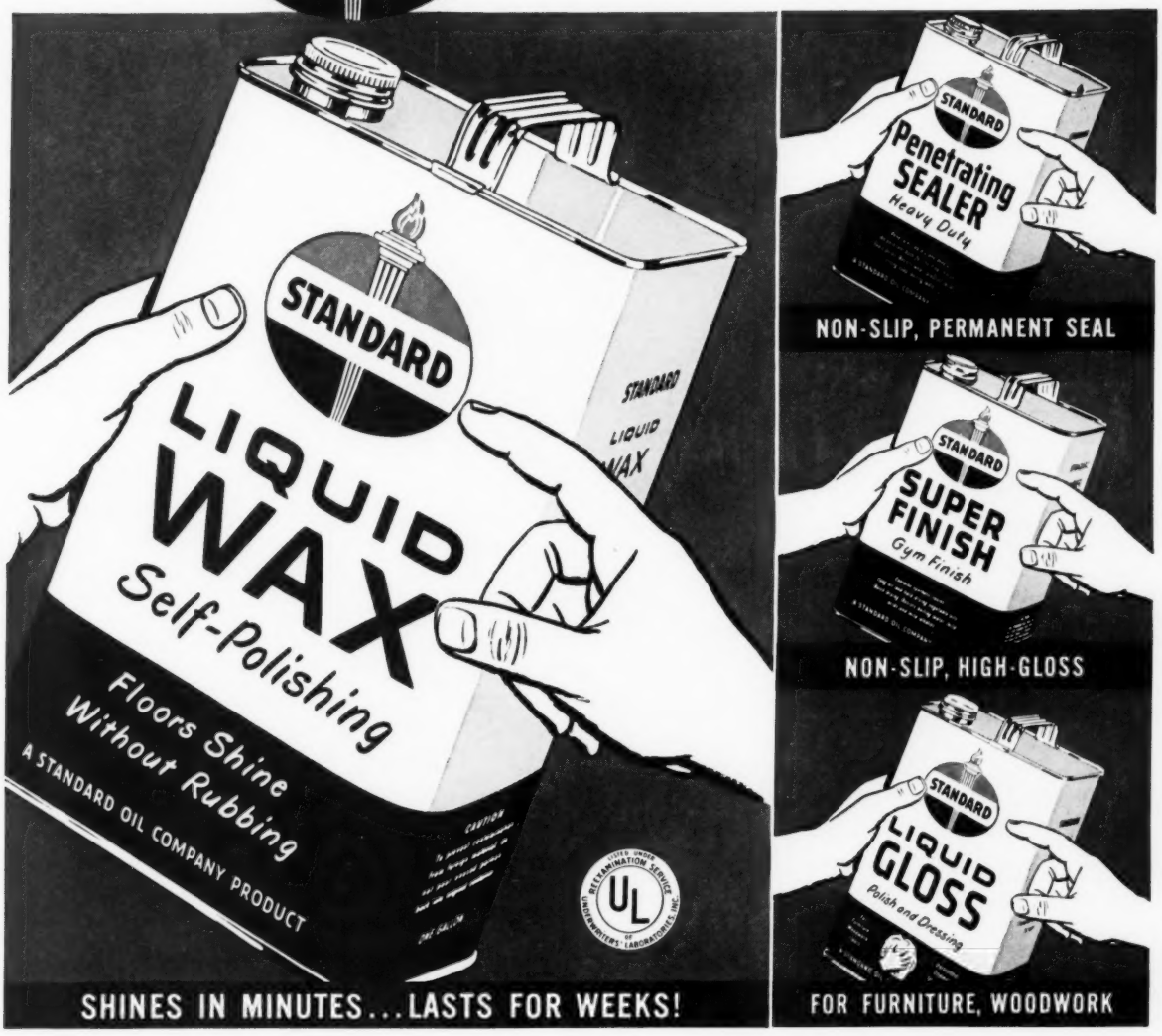

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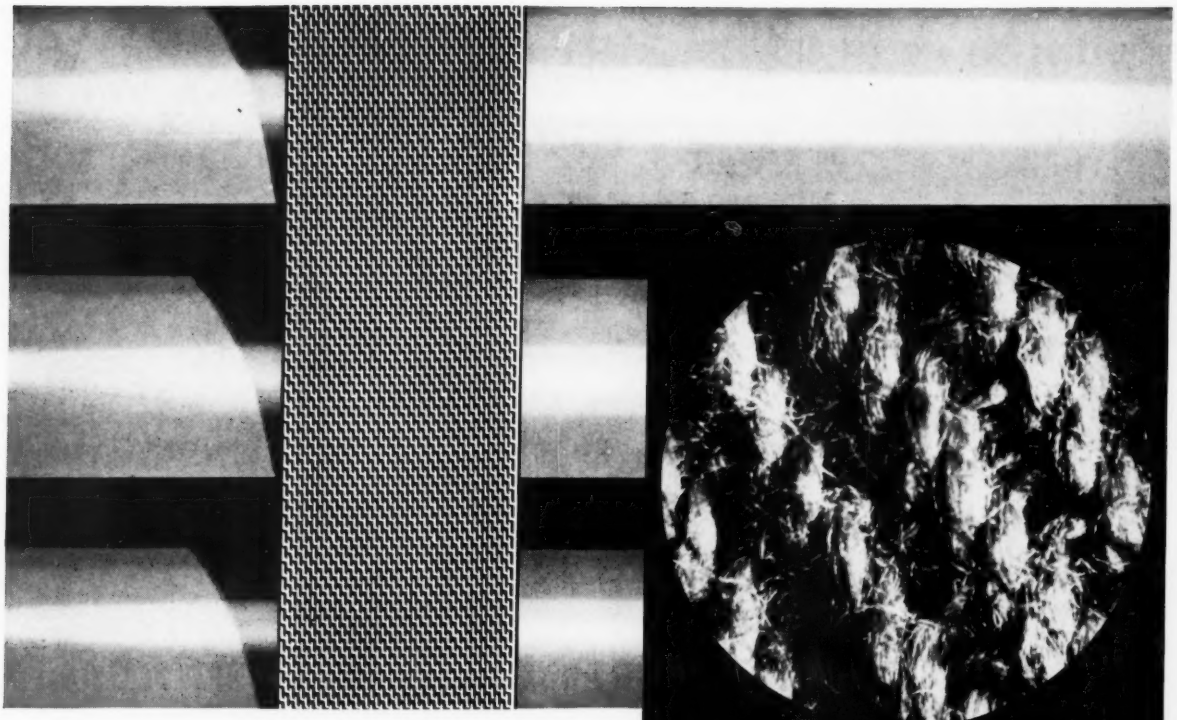
NEWS...

Over-Use of Hospitals by Employes Discussed at South Carolina Meeting

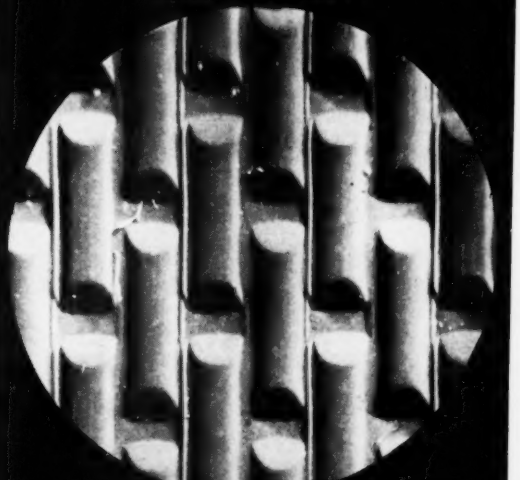
COLUMBIA, S.C.—Charles Robb, administrator of Roper Hospital, Charleston, S.C., and president of the state hospital association, presided at a regular quarterly meeting of the South Carolina Hospital Association held here Friday, July 16. Everett W. Jones, vice president of The Modern Hospital Publishing Company, opened the meeting with a talk on how to explain hospital costs to the public.

"You must start your public education program by explaining thoroughly what has happened to hospital costs, and why, to the hospital trustees, staff doctors, employes and the families of these three groups," said Mr. Jones. He gave typical examples of hotel *vs.* hospital pay-roll costs and then showed the costs of various classifications of employes in the hospitals and selected supply and equipment items in 1940 *vs.* 1954. He urged hospital administrators to get the story of hospitals' loss on caring for indigents over to the general public and to be certain that the full facts were given to all state legislators. Mr. Jones explained the successful job done by the Connecticut Hospital Association in getting hospitals paid for the care of indigents on the government reimbursable cost formula. He also urged hospital administrators and trustees to cooperate with staff doctors in correcting over-utilization and abuse of hospital services.

Mary White, director of nursing education, Memorial Hospital, Anderson, S.C., explained the regional workshop training plan for the training of nurses who, in turn, would go back to their individual states and conduct sectional training shops in their state to train nurses for the important job of operating in-service training programs for nurse's aides. She described the great improvement in patient care when carefully planned nurse's aide training programs are carried out. William Lowrance, administrator of the Self Memorial Hospital, Greenwood, and a trustee of the state hospital association, told the delegates about the reduction in turnover at Self Memorial following the institution of the nurse's aide in-service training program. He said that the turnover had been cut from 100 to 30 per cent. Margaret Richter, in charge of the nurse's aide training program at Self Memorial



Surface of cotton tape,
enlarged 44 times



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NEWS . . .

Hospital, urged the South Carolina Hospital Association to make a financial grant to the state nursing group to help get a nurse aide program started on a statewide basis. Five hundred dollars was pledged by the hospital association toward the budget of $4500.

Most of the afternoon session was spent in a discussion of over-utilization of hospital services by hospital employe groups who are members of Blue Cross. Some hospitals in the state have used up as much as 300 per cent of their premiums in hospital care, it was stated. A special committee was appointed to study this problem and report at the next quarterly meeting.

The meeting unanimously adopted a resolution in memoriam to the late Mrs. Granger Gaither, who had been active in hospital women's auxiliary work in the state and served as South Carolina state auxiliary counselor on the national committee. Isadora Poe, executive secretary of the State Board of Nurse Examiners, discussed student nurse recruitment and put particular emphasis on the importance of all hospitals, with or without nursing schools, conducting a thoroughgoing local recruiting program.

Medical Education Fund Gets Federal Charter

EVANSTON, ILL.—A federal charter has been granted to the National Fund for Medical Education by President Eisenhower, giving the national fund federal corporate status similar to that of the Red Cross or Community Chest, according to fund officials. The fund was established to seek local corporate support for medical schools. A report made by the fund states that the nation's 79 medical schools need an additional $10,000,000 in order to maintain their proper standards.

Rodgers Injured in Automobile Accident

TULSA, OKLA.—Cleveland Rodgers, executive secretary of the Mid-West Hospital Association and also executive secretary of the Oklahoma State Hospital Association, was seriously injured in an automobile accident recently. Velma Neely has been appointed to serve as acting secretary of the Oklahoma State Hospital Association during his absence.

NEWS...

Northwestern Awards Master's Degrees in Hospital Administration

EVANSTON, ILL. — Northwestern University has awarded master's degrees in hospital administration to the following candidates. Their present positions are also given.

Arthur Banning Allaben, assistant administrator, Ferguson-Droste-Ferguson Hospital, Grand Rapids, Mich.; Lillian Harriet Beck, administrative assistant, Du Page County Memorial Hospital, Elmhurst, Ill.; Jay J. Blakely, assistant administrator, East Orange General Hospital, East Orange, N.J.; Ann Thomas Bland, completing her administrative residency at Mound Park Hospital, St. Petersburg, Fla.; James William Cooke Jr., administrative assistant, City Hospital of Akron, Akron, Ohio.; Leon Felson, administrative assistant, Mount Sinai Hospital, Chicago; Woodrow Wilson Fanning, completing his administrative residency at Baroness Erlanger Hospital, Chattanooga, Tenn.; Roderick Arthur Gettel, joining the U.S. Air Force; Leon I. Gintzig, in charge of education and training program, Veterans Administration Hospital, Downey, Ill.; Thomas Variot Griffin, completing his administrative residency at Monmouth Memorial Hospital, Long Branch, N.J.; Joseph Dudley Hall Jr., administrative assistant, Harris Hospital, Fort Worth, Tex.; John A. Hallett, business manager, Clinica Americana, La Paz, Bolivia.

William Donald Hedden, administrative assistant, Methodist Hospital, Memphis, Tenn.; David Robert Jaye Jr., administrative assistant, Wesley Memorial Hospital, Chicago; Roger Burton Labouteley, assistant administrator, Cooley Dickinson Hospital, Northampton, Mass.; William Earl Lafayette, administrative assistant, Freedmen's Hospital, Washington, D.C.; Arthur E. Liebert, administrative assistant, Rochester General Hospital, Rochester, N.Y.; James Willard Loy, assistant director, Hermann Hospital, Houston, Tex.; Malcolm Dean MacCoun, administrative assistant, Malden Hospital, Malden, Mass.; Harold Wayne Maysent, administrative assistant, Passavant Memorial Hospital, Chicago; Earl Charles Mechtensimer, hospital consultant for the Illinois State Department of Public Health, Chicago; Robert C. Moehn, administrative assistant, Milwaukee County

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NEWS...

Institutions and Departments, Milwaukee; William Richard Morgan, completing his administrative residency at Waverly Hills Tuberculosis Sanatorium, Waverly Hills, Ky., and Louisville General Hospital, Louisville.

Keyton Harrison Nixon, assistant administrator, Burge Hospital, Springfield, Mo.; Albert Oscar Pugatch, completing his administrative residency at New England Medical Center Hospital, Boston; Clayton H. Sager, business administrator, Middle Tennessee Tuberculosis Hospital, Nashville, Tenn.; Lee Goodrich Sewall, manager, Veterans Administration Hospital, Downey, Ill.; Roy O. Stadler, completing his administrative residency at Welborn Memorial Baptist Hospital, Evansville, Ind.; Bert Stajich, assistant administrator, Columbia Hospital, Milwaukee; Frank Drexel Toland Jr., administrative assistant, Baptist Memorial Hospital, Memphis, Tenn.; Anne B. Vonovick, completing her administrative residency at St. Joseph Memorial Hospital, St. Joseph, Mich.; Robert George West, completing his administrative residency at California Hospital, Los Angeles; David Lee Winebrenner, Far East Command, U.S. Army; Bernhardt Alexander Zeiher, assistant director, Riverside Hospital, Toledo, Ohio.

AT NORTHWESTERN UNIVERSITY COMMENCEMENT

Graduates in hospital administration who attended commencement exercises at Northwestern University, June 15: Front row, left to right: Lt. David Winebrenner, William Morgan, Arthur Allaben, Ann Bland, Bernhardt Zeiher, Leon Gintzig, Harold Maysent, Dr. Malcolm T. MacEachern (director), Robert Moehn, David Jaye, Ann Vonovick, Leon Felson, Harold Salmon. Back row, left to right: Bert Stajich, George Stout, James Cooke, Roy Stadler, Arthur Liebert, Malcolm MacCoun, Woodrow Wilson Fanning, Earl Mechtensimer, Robert West, Frank Toland, Roger Labouteley, Keyton Nixon, Lt. Ned Curtis, Thomas Griffin.

New Fringe Benefit for Employes

PASADENA, CALIF.—The management of Huntington Memorial Hospital here has arranged to pay the entire Blue Cross premium for all its employes who are retired on pension.

NEWS...

Three Associations Launch Committee to Recruit Medical Technologists

WASHINGTON, D.C. — A campaign to increase the number of medical technologists available to laboratories is under way with the formation of the National Committee for Careers in Medical Technology. The committee is sponsored by the American Society of Medical Technologists, the American Society of Clinical Pathologists, and the College of American Pathologists.

As a part of this program the National Committee for Careers in Medical Technology has received recently a grant of $30,000 from the American Cancer Society and one of $15,000 from the National Cancer Institute of the Public Health Service. These will be used for the production of two films to be used in describing the opportunities of the profession to young people who have shown an interest in science. The films will dramatize the training and work of the medical technologist, especially the importance of his work in assisting the pathologist in performing tests for the detection of cancer.

At the annual convention of the American Society of Medical Technologists a resolution was passed providing for the society to participate in and endorse the National Committee on Careers in Medical Technology. Officers chosen at the convention were: president, Ruth Hovde; president-elect, Barbara Isbell, and recording secretary, Sister Mary Simeonette.

Dr. Allen to Study Belgian Hospital System

HARTFORD, CONN. — Dr. Wilmar M. Allen, former director of Hartford Hospital here, has been appointed consultant in administration and management for the hospital system in Belgium by the U.S. Department of State. He will serve under the Fulbright Foundation at the University of Brussels for the 1954-55 academic year.

Dr. Allen is a former president of the American College of Hospital Administrators and of the New England Hospital Assembly. He is now delegate-at-large to the house of delegates of the American Hospital Association.

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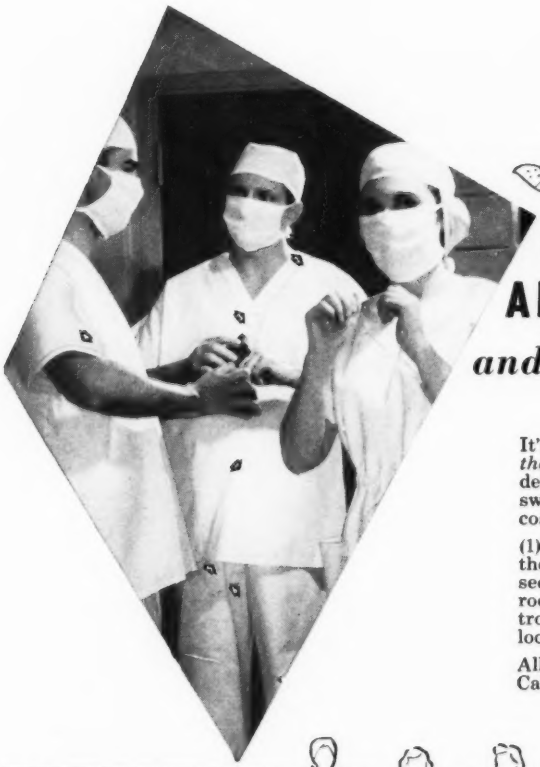

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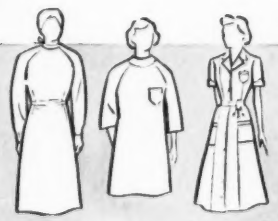

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NEWS . . .

Michigan Sets Up State Hospital Committee

LANSING, MICH.—Rules and minimum standards for hospitals in Michigan are to be controlled by a new committee, known as the (state health) Commissioner's Hospital Committee. This committee is provided for in a bill amending the Public Health Act, which gives the commissioner of health authority to regulate hospitals. The hospital standards bill sponsored by the Michigan Hospital Association did not pass.

The functions of the committee will include the consideration and revision of rules and regulations concerning hospitals, review of provisional licenses granted by the state health commissioner and sitting in on hearings on the suspension, revocation or denial of licenses.

Appointment of members to the committee will be determined by the state health commissioner. It will include five persons from a list of 10 hospital administrators or trustees submitted by the board of trustees of the Michigan Hospital Association, two members from the list of hospital administrators or trustees submitted by the Michigan Osteopathic Hospital Association, and two members at large.

Calls Nursing Career Ideal for Young Negro Women

WASHINGTON, D.C.—Nursing offers an outstanding opportunity for young Negro women to receive status and respect yet to be accorded them in other fields, declared Rep. Frances P. Bolton (R.-Ohio) at a banquet given in her honor by Chi Eta Phi at Howard University recently. The congresswoman was honored for outstanding contributions both in nursing and in race relations.

Mrs. Bolton said the American Nurses Association has played a large part in the battle for better race relations. Before the war 15 state nursing associations would not admit Negroes. Now only the Georgia association has color requirements.

Mrs. Bolton added: "In 1941 only 42 schools of nursing would admit Negroes. Now there are 710. Today some of the nation's most outstanding hospitals—Cook County, University of Kansas, Gallinger and many others—have Negroes on their staffs."

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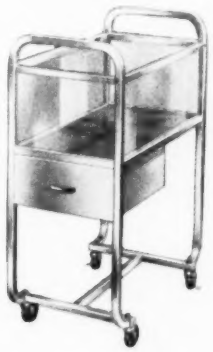
Model P9013. Individual care combination unit including bassinet, dressing stand and storage facilities. Transparent sides eliminate need for cubicles. Ideal for "rooming in" care and isolation. Welded square aluminum tubing. Size, over-all: 30 by 28 by 47 inches.



2. Ravenswood Bassinet

Model P9907. Generous space, 16½ by 28⅝ inches, permits complete care of infant inside bassinet. Welded aluminum frame; transparent Lucite sides. Bottom tilts. Size, over-all: 18 by 30 by 38½ inches. With drawer located on side or end, or without drawer.

3. Cabinet Model Ravenswood Bassinet

Model P9904. Complete individual care with adequate storage space for supplies, blankets, etc. Large compartment accessible from either side through sliding transparent Lucite doors. Drawer has ample capacity for bottles, etc. Size, over-all, 18 by 30 by 38½ inches.

4. New Steeline Pediatric Table

Model P8558. Includes built-in tare balance scale, measuring rod, foam rubber cushion and electrical facilities, built-in paper sheeting roll holder; two roomy drawers; large open compartment with shelf. Construction features all-welded steel body.

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NEWS...

Yale University Announces Student Residencies

NEW HAVEN, CONN.—Students in hospital administration at Yale University have been assigned to their residencies, university officials announced recently. The assignments are as follows:

Lester Milton Bornstein, Charles S. Wilson Memorial Hospital, Johnson City, N.Y.; Asa Robert Crawford, Roosevelt Hospital, New York; Louis Drexler, Bergen Pines County Hospital, Paramus, N.J.; Guy Lee Elliott, U.S. Public Health Service, Staten Island, N.Y.; Morris London, Montefiore Hospital, New York; Daniel Edward Ross, Mount Sinai Hospital, New York; David Vere Shaw, Lowell General Hospital, Lowell, Mass.; Evelyn T. Farnsworth, New England Center Hospital, Boston; Robert Edwin Ward, Hospital of the Good Shepherd, Syracuse, N.Y.; Dr. Francisco Lajarka Vicuna, director of hospitals, Quezon City, Philippines.

YALE HOSPITAL ADMINISTRATION STUDENTS

Front Row, left to right: David Vere Shaw; Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital; Evelyn T. Farnsworth; George S. Buis, director of course in hospital administration; Morris London. Second Row, left to right: Dr. Francisco L. Vicuna, Louis Drexler, Mr. Hastings, Daniel E. Ross, A. Robert Crawford, Guy Lee Elliott, Lester M. Bornstein, Robert E. Ward.

Long-Term V.A. Patients Enjoy Making Toys

WASHINGTON, D.C. — Toy-making has become a vital part of manual arts and occupational therapy clinics in Veterans Administration hospitals.

The majority participating in the program are mental, tuberculous or other long-term patients. The toys, which are sometimes original constructions and more often old ones carefully repaired, are distributed to needy children and orphanages through local agencies at Christmas time.

In the making of these toys, many patients find the satisfaction of being contributing members of their communities. In addition, children who might otherwise be forgotten are provided with playthings.

"The Roosevelt Hospital gets maximum value from everything they buy",

says Wallace O. Banker

Mr. Wallace O. Banker, Purchasing Agent,
The Roosevelt Hospital, New York, N. Y.

Mr. Banker writes, *"With today's costs so important a factor in the operation of hospitals, we here at The Roosevelt Hospital must get maximum value from everything we buy. That's why we use the Utica Muslin sheets and pillowcases as a standard. Replacement costs are at a minimum, and their smooth texture aids the patient's comfort."*

A wise hospital purchasing agent buys value. Sheets and pillowcases must be comfortable and wear well throughout their long life. That's why so many experienced buyers of hospital supplies select Utica Muslin Sheets, woven with over 140 threads to the square inch (finished count). They are made of carefully selected cotton, in one of the most modern mills of its kind in the world. Utica Muslin Sheets fulfill your rigid requirements of high quality and long service at low cost.

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NEWS...

Philadelphia General Nears Completion of Two-Year Building Projects

PHILADELPHIA. — The need for centralizing scattered facilities and eliminating duplication of services dominates the two-year construction and improvement program which is nearing completion at the 222 year old Philadelphia General Hospital.

Notable changes have been made in the central Blockley Division with the construction of a new centralized food service building, which will be one of the best equipped such buildings in the country. Other innovations in this division are a modern neurological building and a renovated psychopathic building, the latter of which now provides improved surroundings having a therapeutic value for patients. A large open ward has been transformed into offices and a reception room, and the occupational therapy department has been enlarged to meet increased needs, it was reported.

The most far-reaching effects of relocation and centralization have been made possible by the transfer of physical medicine patients from obsolete quarters in scattered smaller buildings to the new eight-story, 740 bed Mills Neurology Building, a $7,700,000 structure named for the hospital's first neurological chief, Charles K. Mills. Maximum sunlight, advanced rehabilitation facilities, occupational therapy workshops, a swimming pool and gymnasium for physical therapy are features of this unit.

The last original building of the Blockley Division, a dormitory for employes, was torn down to make way for the $3,600,000 structure which is to house the food storage and preparation area and dining facilities geared to serve 13,500 meals daily. A new dining room replaces the partitioned-off basement storeroom formerly used by employes. Cafeterias in nurses' and doctors' residences will henceforth be used for domitory purposes.

The new foods building is a five-story structure, with a three-story expanse of glass at the main entrance. On the top floor a walnut paneled reading room opens onto a sundeck along two sides of the building. Opposite is a library.

Two large dining areas, identical architecturally, covering 20,000 square feet of space, are located on the third

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"GOOD MEDICINE"
in countless fine hospitals

Personal cleansing, for obvious reasons, is recognized by hospital authorities as "good medicine" for sick folks . . . a definite contribution to the patient's comfort . . . an important factor in speeding convalescence.

For equally obvious reasons, soap for patient care must have thorough cleansing qualities . . . must be gentle . . . must be free from irritating ingredients and strong perfumes.

And here, unquestionably, are the big reasons for the acceptance of Ivory Soap by so many, many fine hospitals.

Ivory's purity is proverbial. No other soap is more gentle in its cleansing action. No other soap lathers more generously—in hard water or soft. And no other fine toilet soap is "gentler" to hospital budgets.

Your patients—yes, and your own personnel—will appreciate Ivory's many fine qualities. *It's a luxury toilet soap at a less-than-luxury price.*

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and fourth floors. In each a central service area divides the dining room, providing duplicate serving facilities for two cafeteria lines. Sliding partitions may be used to set off sections of the large area for smaller dining rooms. All food is prepared on the second floor and is carried to the dining areas on dumb-waiters.

Patients are served from compact movable warming ovens. The stainless metal kitchen has the most advanced kitchen equipment. Separate pastry, salad and special diet kitchens are provided, as well as an adjoining commissary for day-to-day supplies, a classroom for student dietitians, and offices for staff dietitians.

Storage and maintenance services are located on the first floor, which has 35,000 square feet of refrigerated storage space, as well as a room housing equipment for making flaked ice. Special features are a refrigerated room for storing garbage until it is removed, tiled milk can washing and storing rooms, and a meat loading track operating from the receiving platform to the storage room.

Architects for the food service building were Gilboy and O'Malley, with Pennell and Wiltberger consulting engineers. For the Mills Neurological Building, Harbeson, Hough, Livingston and Larson were the architects; Sauter and Castor, structural engineers, and Moody and Hutchinson, mechanical engineers.

Of the vacated buildings, one will be used for centralization of admissions, medical records, and all outpatient care which formerly had been scattered throughout the various departments. Another building will house all laboratories except postmortem, autopsy and the morgue, which will be retained in the old laboratory building, leaving space there for the services of the medical examiner. A $300,000 addition has been made to the maternity building to provide two delivery rooms on the one floor and on the other a central sterile supply.

At the Northern Division, an old nurses' home has been converted into a maternity hospital of 62 beds and two air-conditioned delivery rooms.

Commercial Underwriters of Health Insurance Adopt Code of Ethics

CHICAGO.—A code of ethics was adopted by the Health and Accident Underwriters Conference at a meeting here last month. The conference is a trade association of more than 200 companies writing accident and health insurance. Its membership is said to account for more than 65 per cent of the total business written on an individual basis.

Called "Ethical Standards for Advertising Individually Underwritten Accident and Health Insurance," the code has 14 points. It declares that advertising must be truthful in fact and implication and not have the capacity or the tendency to mislead.

Other standards adopted by the conference cover limitation of introductory offers, use of a name or symbol akin to one popularized by hospital or medical service groups, and false claims of "no medical examination required." Dollar amounts of coverage, length of the benefits, and age requirements are to be clearly stated for "typical policies."

THINGS WE TAKE FOR GRANTED

. . . like America's millions of acres of forests. Yet how important these timber resources are to our defense effort, to almost every industry and individual, to our whole national economy. But they must be guarded with care. Forest fires destroy millions of acres of timber and cost Americans a billion dollars every year. And nine out of ten forest fires are man-caused. They *can* be prevented. Be careful with fire in the woods. Urge others to be careful, too. *Remember, only you can prevent forest fires.*

. . . like pure alcohol in our hospitals. Yet how useful it is for everything from an alcohol rub to a therapeutic nerve block. How dependable in supply. How unvarying in purity. We're proud to play a part in making pure alcohol something you *can* take for granted.

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NEWS...

A.M.A. Abandons Registry of Hospitals

(*Continued From Page 65*)

for the Study of Relations Between Osteopathy and Medicine to visit schools of osteopathy for this purpose.

"It was agreed that each school would be visited by two members of the committee accompanied by an individual of established experience in inspection of medical schools. The studies would be of sufficient duration, breadth and depth to establish the nature and scope of the educational program and determine the quality of medical education provided.

"The conference committee favorably recommended this proposal to the board of trustees of the American Osteopathic Association which considered it at a special meeting on Feb. 6-7, 1954. It has referred the question to its house of delegates which will act upon the proposal in July 1954. If the action of the house of delegates of the American Osteopathic Association be favorable the on-campus observations can be carried out in the fall of this year. . . .

"The committee therefore recommends:

"1. That no action be taken on the report at this time and that final action be deferred until December 1954.

"2. That the committee be continued until December 1954 in order to be available to evaluate education in schools of osteopathy should the house of delegates of the American Osteopathic Association act favorably upon the recommendation of its conference committee."

The house adopted two resolutions regarding veterans' medical care, reaffirming its 1953 policy generally opposing V.A. hospital care for non-service-connected cases, condemning "the present practice of establishing service-connection for veterans' disabilities by legislative fiat," and stating that "the time is at hand when the American Medical Association and its component societies should go all out in preventing this unscientific method of determination of service-connected disabilities. . . . ."

The problem of evaluating the abilities of foreign medical school graduates, a subject which earlier this year attracted major interest at the annual Congress on Medical Education and Licensure in Chicago, was referred for further study to the Council on Medical Education and Hospitals.

In approving the report of another reference committee, the house of delegates rejected two resolutions aimed at the proposed National Blood Program, in which the A.M.A., American Hospital Association, Red Cross, American Association of Blood Banks, and American Society of Clinical Pathologists would participate. The committee denied that the proposed program jeopardized local medical control of blood banking policies and procedures, as charged in resolutions introduced by the delegations from Arizona and Texas. "Your reference committee learned that there is considerable apprehension lest one organization dominate the proposed National Blood Foundation," the report to the house of delegates added. "Your committee can find no basis for such apprehension, since the board of directors of the proposed organization would be composed of two members from each of the five sponsoring

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groups, three of these sponsoring agencies being professional medical societies."

At the opening session of the house, retiring A.M.A. president Edward J. McCormick of Toledo called upon the medical profession to take the guesswork out of medical costs by adopting average fee schedules on an area or regional basis in preference to the traditional sliding-fee system. The house subsequently directed the board of trustees to make a study of such programs. An average, or fixed, fee schedule has a great deal of appeal to patients who have been gouged, unquestionably, and it has the advantage of letting the patient know where he stands without seeking a specific financial understanding with his doctor, but critics have noted that in areas where it has been employed the average, or fixed, fee tends to be not only a maximum but a minimum fee and those who cannot pay this fee are not offered private care at a fee they can afford; rather, they are advised to seek free clinic or charity ward care.

Speaking before the A.M.A. Woman's Auxiliary, Dr. McCormick found occasion to expand on what he called "Fifth Amendment Americans," meaning—well, it was hard to tell whether he was talking about Communists, socialists, federal employes, Democrats or simply people who stood up for what they believed to be their constitutional rights, but, he said, these "Fifth Amendment Americans have made their way into government, educational institutions, churches, fraternal organizations and even medical societies."

In his inaugural address as the new A.M.A. president, Dr. Walter B. Martin pointed out the phenomenal growth in the "machinery of medicine" but deplored the fact that "the very success of medicine in a material way may now threaten the soul of medicine. . . .

"Medicine is something more than the cold mechanical application of science to human diseases. Medicine is a healing art. It must deal with individuals, their fears, their hopes and their sorrows. It must reach back further than a disease that the patient may have to those physical and emotional environmental factors which condition the individual for the reception of a disease. The trend in modern medicine is to separate the patient further and further from the physician as a counselor."

The A.M.A. president stated that 72 per cent of the nation's insurable population is already carrying some form of hospital insurance and suggested further extension of voluntary prepayment plans. "They should expand not only numerically but also in an extent of coverage compatible with sound insurance principles," he concluded.

Dr. Elmer Hess of Erie, Pa., urologist and head of the A.M.A. committee which presented the now-famous "Hess Report" to the house of delegates in 1950, was named president-elect.

Heads Catholic Conference

TULSA, OKLA.—"The Obligation of the Catholic Hospitals to Teach" was the theme of the program at the state conference of Catholic hospitals here. At the meeting Sister Mary Fidelise, C.C.S.F., administrator of Blackwell General Hospital, Blackwell, Okla., was named president of the conference.

NEWS...

Fourth Ruling Given on Iowa Law on Osteopathy

DES MOINES, IOWA.—The question of barring an osteopath from a county hospital supported by public funds was again brought up when Dr. Edward Hermann, osteopath at Crawfordsville, Iowa, asked for permission to use Washington County Hospital, and medical doctors on the hospital staff objected.

The hospital board thereupon requested its attorney to seek an opinion from the attorney general of the state of Iowa. Three opinions on the subject had already been given by the state department of justice.

Clarence Kading, assistant attorney general, who wrote the opinion, stated that, according to Iowa law, an osteopath was a licensed physician and that the patient was at liberty to choose the services of such a person. Since by definition of terms the osteopath is a physician, the board of a publicly supported hospital is not at liberty to exclude this professional person from its hospital staff, Mr. Kading stated.

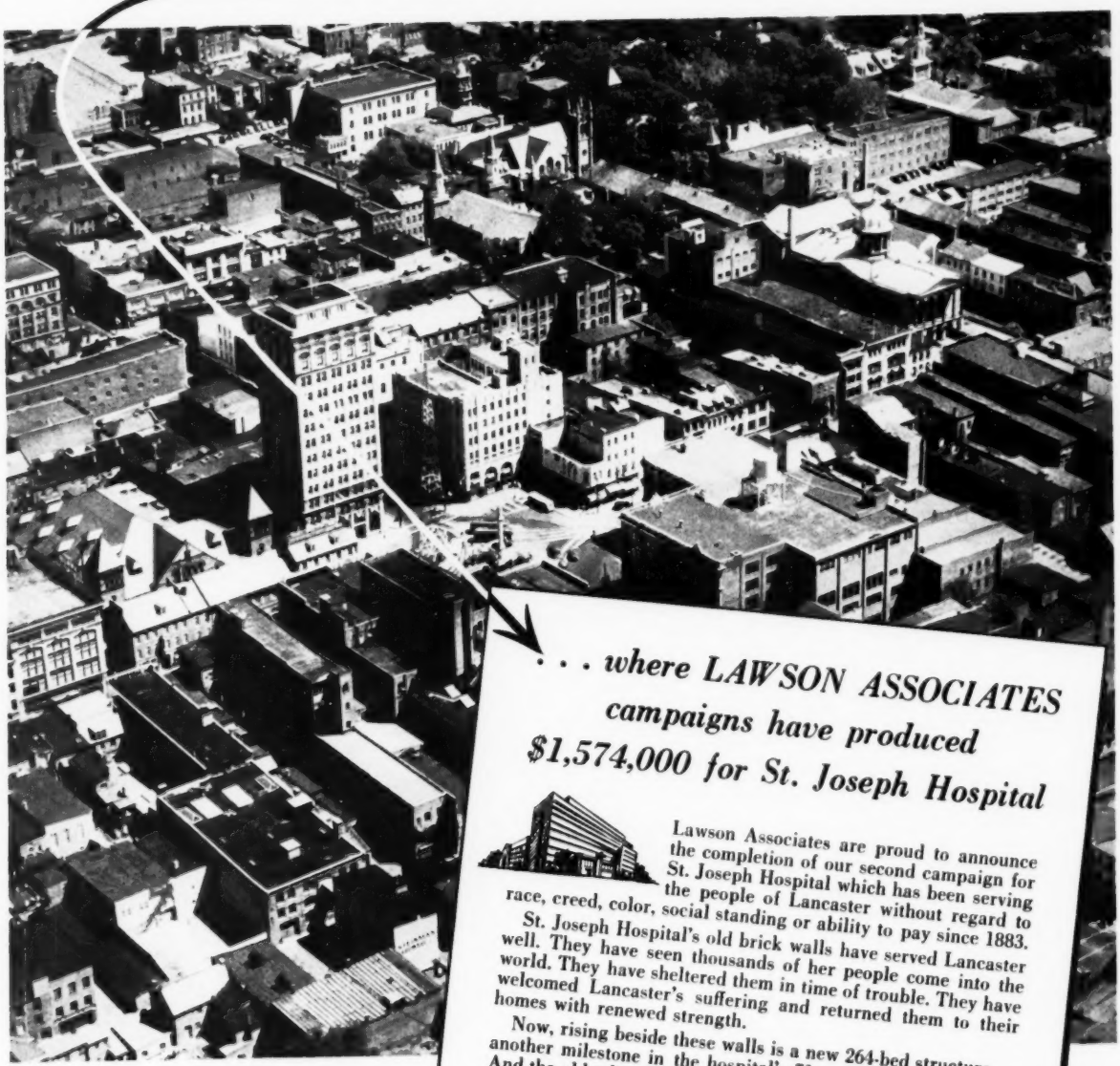
The *Des Moines Register,* in a recent editorial on the subject, supported the inclusion of osteopaths in hospital staffs. "The medical doctors also knew," the editorial said, ". . . or they should have known—what the opinion would be. We wonder just why they raise the question so frequently. We can't see that it does any good except to promote discord and friction in a community. Asking an attorney general's opinion certainly won't change the Iowa law."

Indiana Association Elects Officers

INDIANAPOLIS.—At the annual convention of the Indiana Hospital Association the following officers were named to serve for the coming year. They are:

President, Ralph M. Haas, Montgomery County Culver Union Hospital, Crawfordsville; president-elect, Sister Miriam Dolores, St. Joseph's Hospital, South Bend; vice president, Donald C. Carner, Parkview Memorial Hospital, Fort Wayne; treasurer, Maude M. Woodard, Clinton County Hospital, Frankfort; executive secretary, Albert G. Hahn, Protestant Deaconess Hospital, Evansville, and assistant secretary, Mrs. Albert G. Hahn.

THIS IS LANCASTER, PENNSYLVANIA



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Lawson Associates are proud to announce the completion of our second campaign for St. Joseph Hospital which has been serving the people of Lancaster without regard to race, creed, color, social standing or ability to pay since 1883.

St. Joseph Hospital's old brick walls have served Lancaster well. They have seen thousands of her people come into the world. They have sheltered them in time of trouble. They have welcomed Lancaster's suffering and returned them to their homes with renewed strength.

Now, rising beside these walls is a new 264-bed structure — another milestone in the hospital's 71-year history of service. And the older building will be rehabilitated completely so that it, too, may continue to serve.

Lawson Associates are honored to have served as fund-raising counsel for St. Joseph Hospital in its 1949 campaign which produced $961,000 and in a just-concluded appeal which raised $613,000. It has been a pleasure to work with the dedicated members of its Advisory Board and the responsible citizens who rallied to the support of their hospital.

This is another glowing example of civic-minded business firms and individuals responding to a well-planned and capably-directed hospital campaign under Lawson Associates direction.

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If your hospital needs funds for new building, expansion, rehabilitation or debt reduction, Lawson Associates' expert advice is as near as your telephone. Just ask your operator to telephone Mr. James Fraser, *collect*, at Rockville Centre 6-0177. We will be most pleased to analyze your fund-raising potential and arrange a cost-free survey of your area of service.

NEWS...

Oklahoma Insures Against Polio, Cancer

TULSA, OKLA.—To those enrolled in both Oklahoma Blue Cross and Blue Shield new extended benefits have been announced. The new program covers 11 catastrophic illnesses, including polio and cancer.

Up to $5000 additional coverage under Blue Cross and up to $2000 additional coverage under Blue Shield is provided for these 10 illnesses: polio, scarlet fever, rabies (prophylaxis and treatment), cerebrospinal meningitis, diphtheria, leukemia, tularemia, tetanus (treatment only), and smallpox.

Up to $1200 additional coverage under Blue Cross and up to $500 under Blue Shield is provided for cancer.

The extended benefits are provided, for the 11 diseases only, in addition to regular benefits of Blue Cross-Blue Shield, and for each member of the family, for treatment of each disease during a two-year period after diagnosis. The cost for extended benefits' protection is 80 cents a month for family membership and 40 cents a month for one-person membership.

Hospital Industries Group Adopts Code of Ethics

CHICAGO.—A code of ethics for exhibitors at hospital conventions has been adopted by the Hospital Industries' Association and approved by most of the hospital associations holding conventions with exhibits, William E. Smith, H.I.A. executive director, announced here recently.

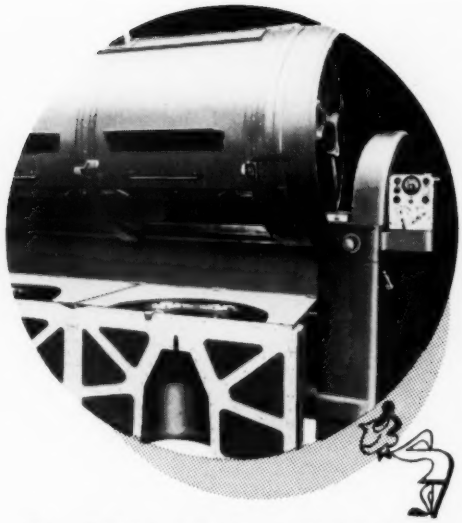
The code defines ethical conduct as including observance of the following regulations:

1. Prospects should not be contacted in other exhibitors' booths.
2. Prospects should not be solicited in the aisles.
3. All selling and demonstrations should be confined to exhibitors' booths.
4. Sample giving should not interfere with other exhibitors' space.
5. All contests, prizes or lotteries are prohibited.
6. The use of sample bags and baskets is discouraged.
7. Booth activity should not cut off, obstruct or otherwise interfere with exhibits in adjacent booths.
8. Exhibitors' badges are personal and are not transferable.
9. Displays should not be dismantled before the officially designated hour.

Mayor Thinks New York Hospital Plan Is Best

NEW YORK.—To evolve an intelligent hospital system, voluntary and publicly operated hospitals must work together, Mayor Robert Wagner told the Post-Graduate Alumni Association of New York University-Bellevue Medical Center at a recent dinner here. The voluntary agencies in that city, he said, have left the whole field of tuberculosis and mental health to governmental agencies and in many areas the care of the aged as well. This pattern, including the city's other municipal hospitals, is a model that could well be copied in other large cities, the mayor maintained.

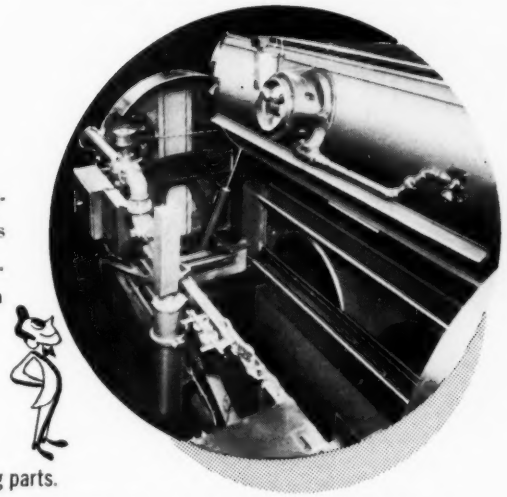
raise the cylinder



Below. Shell and cylinder shown in raised position. Note complete accessibility of all working parts, including dump valve, to permit rapid maintenance.

see for yourself why HOFFMAN surpasses all others for ease of maintenance

Other unloading washers *may claim* to increase your laundry production . . . but only HOFFMAN can deliver this promise. That's because HOFFMAN's simplified design *makes maintenance easy . . . speeds adjustments*—goes back into service quickly to keep right on increasing your production for the same floor area.



Below. Close-up of V-belt and chain drive, for washer drive. Ultra-simple to adjust and repair.

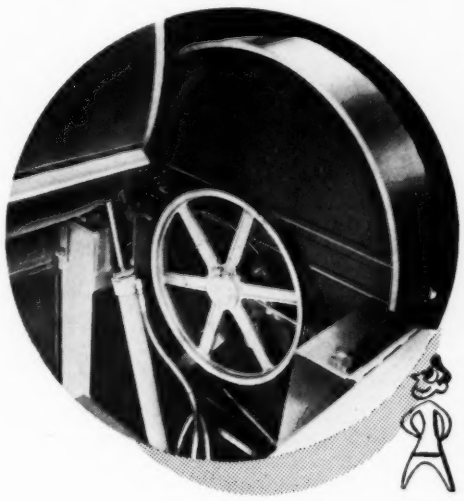
check these exclusive HOFFMAN features:

- ✓ Every part of the washer is within easy reach.
- ✓ Hydraulic raising of shell and cylinder quickly uncovers all working parts.
- ✓ Simple V-Belt and chain drive . . . provide effective transmission.
- ✓ Hoffman has fewer moving parts than any other washer.
- ✓ **One** knob controls all operational stages.
- ✓ Minor repairs can be made without disassembly.

ONLY HOFFMAN combines these unique features *with fast, automatic unloading* . . . designed to save manpower, pulling time, wear and tear on your linen.

Compare the HOFFMAN 42″ with other unloading washers and you will join economy-wise institutional laundries who have selected HOFFMAN to get *all the benefits of increased sustained production.*

Available in three sizes with 225, 350 and 400 lb. capacities. Write for bulletin A-851.



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NEWS . . .

N.Y.C. Doctors Warned on Injury Cases

NEW YORK.—Abuses in the collection of medical fees from workmen's compensation cases have been brought to light by Archie O. Dawson, head of a state commission, who has been studying administration and costs of the workmen's compensation program.

Mr. Dawson found that there were several municipal hospitals in New York City in which physicians had ignored the law by collecting fees for work done by other physicians on the staff. The law provides that workmen's compensation funds cannot be paid to physicians who have not provided services for a particular patient. This is to prevent overcharging and fee splitting. In a number of hospitals Commissioner Dawson found that physicians had been compelled to participate in these violations as a condition of remaining on a hospital staff. The primary responsibility, he stated, lay with the hospital administration.

The city's acting commissioner of hospitals, Maurice H. Matzkin, and representatives of voluntary and private hospitals and officers of the New York County Medical Society agreed to cooperate in ending any of these abuses that came to light. Dr. David Kliski, director of the workmen's compensation bureau of the state medical society, said that the problem "is not so much the interpretation of the law as the willingness of the institutions to cooperate with the law."

P.H.S. Conducts Tests on Hospital Utensils

WASHINGTON, D.C.—A different type of stainless steel made with chrome rather than nickel is being tested by the Public Health Service for the manufacture of clinical utensils. Nickel steel has been in short supply in the past since nickel is used as a war material, it was explained.

The items under study are urinals, bedpans, catheter trays and kick-buckets. Six of each utensil (three made from nickel steel and three from chrome steel) were tested in "identical" conditions in Wesley Memorial Hospital, Chicago, for a year. Then they were examined by metallurgists from the Bureau of Standards in Washington. It was recommended that the test be continued for another year, preferably in a seaside military hospital so that the effects of regular usage and of salt air in combination would demonstrate the degree of difference between the two types of steel.

A.S.T.A. Gives Two Scholastic Awards

CHICAGO.—The American Surgical Trade Association recently made its first award for outstanding scholastic work among students in hospital administration at Northwestern University at a reception at the Chicago campus of the university. Recipients of the award were Leon Felson, now administrative assistant, Mount Sinai Hospital, Chicago, and Woodrow Wilson Fanning, who is completing his administrative residency at Baroness Erlanger Hospital, Chattanooga, Tenn.

A.S.T.A. Secretary Frank Rhatigan presented the awards, each consisting of United States savings bonds valued at $150, to Mr. Felson and Mr. Fanning on behalf of the association.

The first truly elastic bandage the dryer won't "kill"

Even in the autoclave, new TENSOR with Heat-Resistant live rubber threads won't lose its stretch

Here's the first truly elastic bandage that doesn't require *special handling* at the laundry to protect its stretch . . . the first elastic bandage that heat won't hurt.

The Heat-Resistant live rubber threads in new Tensor can stand temperatures up to 280° F. with no appreciable loss of elasticity. They are virtually unaffected by the high heat of commercial or hospital drying equipment.

The result: Tensor lasts much longer . . . and costs less to use. Even after many, many launderings, you can still rely on Tensor to provide the steady, easy-to-control pressure that made it famous as the first truly elastic bandage.

Have you ordered new Tensor yet? It's available (at no increase in cost) in hospital bulk put-ups. Why not specify Tensor next time you stock up on medical supplies?

COMPARE THESE ELASTIC BANDAGES

❶ Bandage with ordinary rubber

❷ TENSOR

❶ One-foot length of bandage made with ordinary rubber is stretched after high temperature drying—and stays stretched. Its elasticity "died" in the dryer.

❷ But one-foot length of heat-resistant Tensor snaps back to its original length, even after prolonged exposure to near scorching heat of commercial dryer.

New TENSOR® ELASTIC BANDAGE

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NEWS...

COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Shoreham Hotel, Washington, D.C., Sept. 13-15.

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Accounting Conference, Springfield, Ill., Oct. 13, 14.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8.

AMERICAN ASSOCIATION OF NURSING HOMES, Annual Convention, Seelbach Hotel, Louisville, Ky., Oct. 18-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Meeting, Palmer House, Chicago, Sept. 11-13. ***Institutes for Hospital Administrators:*** 6th Western Institute, Stanford University, Palo Alto, Calif., Aug. 2-13; 22d Chicago Institute, University of Chicago, Aug. 31-Sept. 10; 5th Chicago Advanced Institute, University of Chicago, Sept. 6-10; 9th Southern Institute, Richmond, Va., Nov. 1-5.

AMERICAN DIETETIC ASSOCIATION, Commercial Museum and Benjamin Franklin Hotel, Philadelphia, Oct. 26-29.

AMERICAN HOSPITAL ASSOCIATION, Navy Pier, Chicago, Sept. 13-16.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Shoreham Hotel, Washington, D.C., Oct. 16-22.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Annual Meeting, Hotel Baker, Dallas, Tex., Oct. 21-Nov. 3.

ARIZONA HOSPITAL ASSOCIATION, Hotel Westward Ho, Phoenix, Nov. 15-17.

CALIFORNIA HOSPITAL ASSOCIATION, Hotel Californian, Fresno, Oct. 28, 29.

COLORADO HOSPITAL ASSOCIATION, Annual Convention, Cosmopolitan Hotel, Denver, Oct. 26-27.

CONNECTICUT HOSPITAL ASSOCIATION, Southern New England Telephone Company Auditorium, New Haven, Nov. 10.

FLORIDA HOSPITAL ASSOCIATION, Annual Meeting, Colonnades Hotel, Palm Beach Shores, Nov. 17-19.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 2, 3.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 11, 12.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Annual Conference, Hotel Shoreham, Washington, D.C., Nov. 15, 16.

MISSISSIPPI HOSPITAL ASSOCIATION, 23d Annual Convention, Hotel Heidelberg, Jackson, Oct. 13-15.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Dec. 2, 3.

NEBRASKA HOSPITAL ASSOCIATION, Hotel Fontenelle, Omaha, Oct. 14, 15.

ONTARIO HOSPITAL ASSOCIATION, Annual Convention, Royal York Hotel, Toronto, Ont., Oct. 25-27.

WASHINGTON STATE HOSPITAL ASSOCIATION, Chinook Hotel, Yakima, Sept. 29, 30.

1955

MASSACHUSETTS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Statler, Boston, May 25.

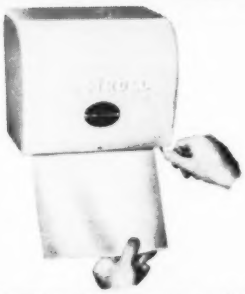
NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Annual Convention, Palmer House, Chicago, Feb. 9, 10.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, March 7-10.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga. April 20-22.

WISCONSIN STATE HOSPITAL ASSOCIATION, Milwaukee, March 17.

eliminate towel waste with WESTROLL!



The Westroll towel dispenser has relatively few working parts, so its maintenance factor is negligible. Westroll dispensers are streamlined, easy to keep clean. They assure a constant supply of towels, help keep washrooms spic and span, save costly janitors' time.

It's human nature to take advantage of an overly generous paper towel dispenser. Particularly so with interfold or flat towels where two, three or even four are used for one drying. But with Westroll, people tend to take just enough and no more. You save as much as 40% on towel costs.

Tests show Westroll users average only 17 inches of paper, against 22, 33, or 44 inches of interfold. Users can crank out exactly the amount of towel necessary – even as little as two inches for lipstick removal! These are immediate savings.

You also save on maintenance. One filling of a Westroll micromatic dispenser is equivalent to *four* fillings of the ordinary flat-towel dispenser. Westroll dispensers are loaned and maintained by West.

Westroll towels are outselling our interfold towels 20 to 1. No customer has ever switched back to interfold towels after trying Westroll!

WEST DISINFECTING Company

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I'm interested in:

☐ A FREE leaflet on WESTROLL.

☐ A talk with a West expert about my washroom problems. No sales pitch. No obligation. Just discussion and a demonstration if I want it.

NEWS...

Hospital Council Surveys Length of Patient Stay

NEW YORK.—Fifteen general hospitals throughout the country have been surveyed by the Hospital Council of Greater New York in regard to length of patient stay over the past decade. The survey was an informal one, done by the questionnaire method.

An interpretation of the statistics gathered has been made by the council as follows:

"1. The mean length of patient stay in the 15 hospitals has declined from 10.5 days in 1943 to 7.7 days in 1953. The arithmetic mean is the average most commonly used by the layman as well as by the statistician. It is the sum of the patient days incurred by a group of discharged patients divided by the number in the group.

"The means of the 15 hospitals are close to the average lengths of patient stay in all voluntary general hospitals in the United States for the corresponding periods. The latter figures are 10.0, 8.5 and 7.7 days in 1943, 1948 and 1953, respectively.

"2. Patients with a long-term stay have decreased both in number and as a percentage of the total. Up to a length of stay of six days the percentage of patients discharged in 1953 exceeds the percentage discharged in 1943. Beginning at seven days the percentage discharged in 1953 is less than the corresponding percentage in 1943. Even in terms of absolute numbers, there are fewer patients in 1953 at almost every length of stay, beginning at 10 days.

"3. The median length of patient stay has declined from 7.8 days in 1943 to 4.9 days in 1953. The median length of stay is the halfway point in an array of discharged patients arranged according to length of stay. One-half of the patients are above this point and one-half fall below it.

"4. The mean length of stay exceeds the median. In 1943, 1948 and 1953 the differences between the two measures are 2.7, 3.2 and 2.8 days, respectively.

"5. A marked difference between the mean and the median of a distribution is indicative of the existence of "skewness." Skewness is the statistical term for asymmetry, or a departure from the normal, bell-shaped curve. In this instance, the point of concentration is at the left, or short stay, end of the distribution. Computation of the degree of skewness by formula indicates an accentuation of this characteristic between 1943 and 1953. With perfect symmetry, the measure of skewness is zero. A value of 0.1 indicates a moderate degree of skewness; 0.24 indicates marked skewness.

"6. Just as the mean or median is a measure of central tendency of a distribution, dispersion is the measure of spread of points about the central tendency. One measure of dispersion is the quartile deviation, or half the difference between the third and first quartiles. The third quartile is the 75th percentile point in a distribution arranged as an array, in the same way that the median is the 50th percentile; the first quartile is the 25th percentile.

"The quartile deviation of the 1943 distribution is 4.3 days; it is 3.3 days in 1953. Relative dispersion, however, as measured by dividing the quartile deviation by the corresponding median, increased from 0.55 to 0.65.

(*Continued on Page* 172)

NEWS...

(*Continued From Page* 170)

"A decrease in the length of patient stay in the general hospital, as measured by the arithmetic mean, may reflect a number of different underlying developments.

"One possibility is that every patient group, whether classified by diagnostic condition or by type of accommodation occupied, has experienced a proportionate reduction in length of stay. A second possibility, which is more likely, is that every patient group has experienced a reduction in length of stay but not at equal rates. A third possibility, which appears unlikely, is that the entire decrease in length of stay is accounted for by a shift in the relative importance of patient groups, with those who have had a short length of stay gaining in importance and those who have had a long stay declining in importance.

"An illustration of this possibility would be an increase in the number of patients in semiprivate accommodations, who usually have a shorter average length of stay, offsetting a decrease in the number of patients in the ward, who generally have a longer average stay. A fourth possibility is that in addition to the types of patient who were in the hospitals in 1943 there is now in the hospitals a new group of patients who are characterized by a much shorter stay than the former. Finally, a combination of the several possibilities, to varying degrees, is probable."

The following hospitals took part in the survey:

Baptist Memorial, Memphis, Tenn.; Charles T. Miller, St. Paul; City, Cleveland; Doctors, Seattle; Greenwich, Greenwich, Conn.; Harper, Detroit; Jackson Memorial, Miami, Fla.; Mary Hitchcock Memorial, Hanover, N.H.; Memorial, Worcester, Mass.; Methodist of Southern California, Los Angeles; Montreal General, Montreal, Que.; New Britain General, New Britain, Conn.; Newton-Wellesley, Newton Lower Falls, Mass.; Princeton, Princeton, N.J.; Rochester General, Rochester, N.Y.; Royal Victoria, Montreal, Que.; St. Barnabas, Minneapolis; St. Joseph's, Phoenix, Ariz.; St. Luke's, St. Louis; Touro Infirmary, New Orleans; Vancouver General, Vancouver, B.C.; Washoe Medical Center, Reno, Nev.

Blue Cross Accepts American Hospital in Paris

PARIS. — The American Hospital here has been accepted by the Blue Cross Commission as a member hospital. It is the first time that a Blue Cross member hospital has been located outside the United States, its territories and Canada, Blue Cross officials stated.

Subscribers who are hospitalized in the American Hospital will receive benefits on the same basis as those hospitalized in the Plan's other hospitals.

The American Hospital in Paris is a privately endowed, 150 bed institution, incorporated under the laws of the District of Columbia. It was recently approved by the Joint Commission on Accreditation of Hospitals. The medical staff comprises a number of Americans, and the board of representatives of the United States government, business and professional governors is made up of American leaders.

NEWS...

Association Survey Terms Mental Health Facilities "Archaic and Inadequate"

NEW YORK.—Mental hospital and affiliated mental health services have been operated in most states in ways that are "archaic, inadequate and ill-fitted for the job to be done," it was asserted in the report of a two-year study by the National Association for Mental Health, released last month. According to Raymond G. Fuller, who conducted the study, the most desirable system for most states would be a "separate coordinate department of mental health. However, only 10 states have such departments; the remaining states have departments which are inadequate to the greatly expanded task which they are called upon to perform," Mr. Fuller said.

Intensive, comprehensive research into every phase of mental illness and adequate training facilities for all groups of psychiatric personnel are necessary, continued Mr. Fuller, if states are to provide more than custodial care for mental patients. He pointed out that states are spending half a billion tax dollars a year on their mental health services but that only 2 cents of every dollar spent on medical research is spent for research in mental illness, although direct expense for mental illness in 1952 amounted to one-third of the nation's expenditure for medical care.

Blue Cross-Blue Shield Offer Hospital Seminars

CHICAGO.—A total of 543 hospital workers representing 148 member hospitals in Illinois attended special seminars given for hospital administrative personnel by representatives of the Blue Cross and Blue Shield. Plan benefits, admitting and billing procedures, and processing of cases were explained with step-by-step demonstrations of the completion of forms. A highlight of the seminars was a true-false quiz which emphasized the important features of certificates, benefits and procedures, which were then discussed by a panel of Blue Cross and Blue Shield personnel.

A.J.N. Offers Award

NEW YORK.—The *American Journal of Nursing* has announced that entries are now being accepted for the 1955 Mary M. Roberts Fellowship Award. Open to professional nurses, the fellowship provides for a year's study with major emphasis on writing and journalism at a recognized college or university. The award was established in 1950 in order "to assist a qualified professional nurse to prepare herself for writing about nursing."

ABOUT PEOPLE

(*Continued From Page* 88)

Richard Brooke

Richard Brooke, who has recently completed his residency in hospital administration at Riverside Hospital, Newport News, Va., and at Memorial Hospital, Danville, Va., is now administrator of Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va. Mr. Brooke is a graduate in hospital administration from the Medical College of Virginia.

Richard H. Ward, administrative assistant in charge of outpatient service at Roosevelt Hospital, New York City, has been named assistant director of the hospital. Mr. Ward holds a master's degree in hospital administration from Columbia University School of Public Health. **Alvin J. Conway,** who has completed his residency in hospital administration at Lebanon Hospital, New York City, and has been awarded a master's degree in hospital administration from Columbia University, is the new administrative assistant.

W. A. Spencer, who has been business manager for the King's Daughters Clinic, Temple, Tex., since 1938, is now administrator, succeeding **Ruby B. Gilbert** who has resigned.

Dr. George Etling, director of St. Lawrence State Hospital, Ogdensburg, N.Y., has been named director of Wassaic State School, Wassaic, N.Y. He is succeeded by **Dr. Herman B. Snow,** assistant director of Utica State Hospital, Utica, N.Y. Another appointment by the New York State Department of Mental Hygiene is that of **Dr. I. Murray Rossman,** who has been assistant director at Kings Park State Hospital, Kings Park, to be administrator at Gowanda State Homeopathic Hospital, Gowanda.

Thomas J. Paden, administrator of the Emily P. Bissell Sanatorium, Wilmington, Del., has become administrator of Memorial Hospital of Bedford County, Everett, Pa.

Robert I. Beers, who has been executive secretary of Methodist Children's Home, St. Louis, is now director of Lake Bluff Children's Home, Lake Bluff, Ill.

John M. Shaw, a recent graduate in hospital administration from St. Louis University who served his administrative residency at Barnes Hospital, St. Louis, has been named administrator of Gibson Community Hospital, Gibson City, Ill., succeeding **Peter J. Alexander** who has accepted an administrative position in a hospital at Clinton, Iowa.

Dr. John L. Wilson, medical officer of the U.S. Public Health Service Hospital, Manhattan Beach, Brooklyn, N.Y., has been transferred to the Public Health Service Hospital, Staten Island, N. Y., succeeding **Dr. Kenneth R. Nelson,** now serving at the Public Health Service Hospital, San Francisco. Other medical officers transferred in Public Health Service Hospitals are: **Dr. Charles R. Mallary,** from San Francisco to Baltimore; **Dr. Richard B. Holt,** from Fort Worth, Tex., to Norfolk, Va.; **Dr. Frank F. Thweatt,** from Norfolk, Va., to Memphis, Tenn., and **Dr. Erwin W. Blatter** from Memphis, Tenn., to Manhattan Beach, Brooklyn, N.Y.

Dr. James V. Lowry, chief of community services branch, National Institute of Mental Health, Washington, D.C., is now medical officer in charge of the Public Health Service Hospital, Lexington, Ky., succeeding **Dr. Kenneth W. Chapman,** who has become

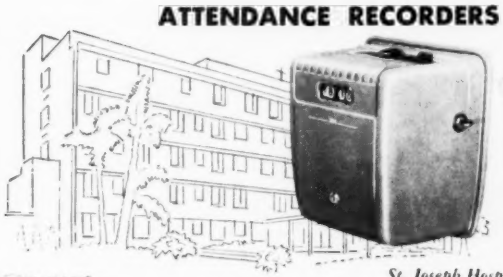
Our Lady of Peace Hospital
Louisville, Kentucky

MASTER TIME CONTROLS

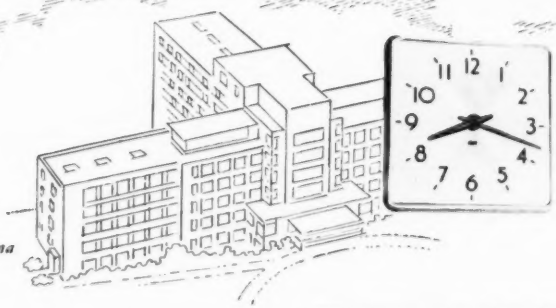
DOUBLE DIAL CLOCKS

St. Luke's Hospital
Milwaukee, Wisconsin

ATTENDANCE RECORDERS



St. Joseph Hospital
Burbank, California



Baton Rouge General Hospital
Baton Rouge, Louisiana

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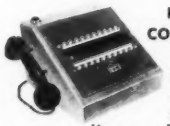


NURSE-PATIENT COMMUNICATING SYSTEM
Microphone-speaker units at bedside and cradle-type phone at nurses' desk make immediate personal contact between patient and nurse. Saves nurse many steps. Assures patient fast service.

DOCTORS' REGISTERING SYSTEM
Signals doctor's presence in hospital. ON-OFF switch illuminates name on all registers in system as doctor enters. Recall feature—name flashing—notifies doctor of messages.

DOCTORS' PAGING SYSTEM
Activated by push button, doctor's code number, set in keyboard, flashes on all annunciators in system. Several calls may be flashed in sequence. Special arrangements made for emergency signaling.

chief, neuropsychiatric branch, division of hospitals, Public Health Service, Washington, D.C.

Dr. Victor H. Vogel, medical officer in charge of foreign quarantine activities, U.S. Embassy, Paris, France, is now in charge of the Public Health Service Outpatient Clinic, Los Angeles and San Pedro, Calif., succeeding **Dr. Fletcher C. Stewart,** who has retired.

Ralph G. Hutchins, formerly assistant superintendent of Hackley Hospital, Muskegon, Mich., has accepted the post of assistant superintendent at White Cross Hospital, Columbus, Ohio. Mr. Hutchins holds an M.A. in hospital administration from Northwestern University.

Neil C. Wortley, who was administrative assistant at Burge Hospital, Springfield, Mo., has become administrator there. Mr. Wortley received his master's degree in hospital administration from Washington University, St. Louis, and is a member of the American Hospital Association and of the Missouri Hospital Association.

W. S. Chapman is now administrator of Arkansas City Memorial Hospital, Arkansas City, Kan.

Dr. Irving J. Cohen, who has been manager of the Veterans Administration Hospital, Baltimore, has been appointed to the central office of the V.A. in Washington, D.C., as deputy director for hospitals. Dr. Cohen received his M.D. from the University of Maryland.

R. O. Lugar, administrator of Watkins Memorial Hospital, Quitman, Miss., has become administrator of Claiborne County Hospital, Port Gibson, Miss. **Jeanette Pettis** succeeds him as administrator at Quitman.

Robert L. Neal, assistant administrator and controller at Suburban Hospital, Bethesda, Md., has been named administrator of F. W. Black Community Hospital, Lewistown, Pa. He succeeds **Esther Elcock,** who is now director of the Home for the Aged of the Methodist Church, Baltimore.

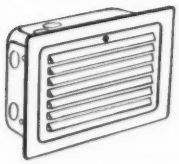
William S. Murphy, who has been administrator of Somerset City Hospital, Somerset, Ky., is now administrator of Good Samaritan Hospital, Lexington, Ky., succeeding **Walther B. Phelps,** who has resigned. Mr. Murphy is a member of the American Association of Hospital Accountants and of the A.C.H.A.

Dr. Linus A. Zink, formerly director of hospitals and clinics of the Veterans Administration, Washington, D.C., has been named deputy direc-

DAY-BRITE NITE LIGHTS, EXIT SIGNS

SAFEGUARD YOUR CORRIDORS

FOR PATIENTS, VISITORS AND STAFF



DAY-BRITE NITE LIGHT

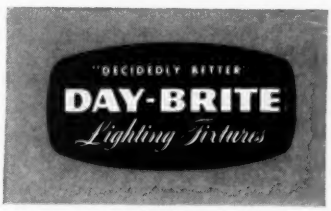
These trim, inexpensive hospital units recess into the wall—an unobtrusive but important safety precaution in corridors and patient rooms during the night hours. The louvered face directs soft light downward—just enough to permit your staff to work efficiently and safely, but not enough to interfere with patients' comfort. Available in stainless steel or lustre aluminum finish, Day-Brite Nite Lights are easy to clean, simple to maintain, cost almost nothing to operate.

DAY-BRITE EXIT SIGNS

A series of handsome, modern units meeting the recommendations of the National Fire Protection Ass'n. Day-Brite Exit Signs locate key stairways and doors to regulate normal traffic and serve as life-saving guides in case of emergency. For positive protection, all signs are equipped with two porcelain sockets to assure continuous operation in the event one lamp fails. A complete line for all types of installation, with or without directional arrows. UL approved.

The two Day-Brite fixtures described above are only part of the complete line of quality fixtures Day-Brite makes.

Hospital lighting requirements are many and exacting. You can't afford to risk money on inferior, cheaply made lighting equipment. Your one best guarantee of the most for your money is the name "Day-Brite" on the fixture you select. It pays to COMPARE DAY-BRITE . . . FEEL THE DIFFERENCE . . . BEFORE YOU BUY!



Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Mo.
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487

ASK YOUR ARCHITECT ABOUT DAY-BRITE LIGHTING

tor for operations of the department of medicine and surgery in the central office of the Veterans Administration, Washington. Dr. Zink is a graduate of Ohio State University Medical School and is a member of the American College of Hospital Administrators.

Marvin A. Chapman is the new director of the Veterans Administration's program for domiciliary homes and centers for disabled veterans. The V.A. maintains 17 "homes" throughout the nation for eligible veterans who have disabilities which prevent them from earning a living and who require minimal medical attention. Mr. Chapman has been with the V.A. since 1946.


Dorothy Morgan

Dorothy M. Morgan, director of nursing, administrative assistant of the University of Chicago Clinics and assistant professor of education at the university, is now administrator of the Elizabeth Steel Magee Hospital, Pittsburgh. Miss Morgan is a graduate of the University of Chicago program in hospital administration. She is a member of the American Hospital Association, the American and Canadian nurses' associations, and the National League for Nursing.

Correction

In reporting the appointment of **Robert Pierce Lawton** as administrator of Danbury Hospital, Danbury, Conn., in this column last month, it was erroneously stated that Mr. Lawton had been administrator of Mary Fletcher Hospital, Burlington, Vt., before going to Danbury. His position at Mary Fletcher Hospital was that of assistant administrator.

Department Heads

Mrs. Madge H. Sidney, executive housekeeper at Evanston Hospital, Evanston, Ill., for the last seven years, has resigned that position effective August 1. She will be succeeded at Evanston by **Mrs. Patricia M. Boyer,** executive housekeeper of the Clinical Center Hospital, National Institutes of Health, Bethesda, Md. Before going to Bethesda, Mrs. Boyer was executive housekeeper at Walter Reed Army Hospital, Washington, D.C. Mrs. Sidney is a member of The MODERN HOSPITAL editorial advisory board. She plans to continue in the hospital housekeeping field in Seattle.

Dr. Lester M. Fox, assistant chief of the laboratory at Brooklyn Veterans Administration Hospital, Brooklyn, N.Y., is now director of laboratories of the Church Charity Foundation of Long Island, Brooklyn, N.Y.

Elizabeth R. Prichard, who has been assistant social service director at Presbyterian Hospital, New York City, since 1949, has become director of the social service department, succeeding **Mercedes Gyer,** who has retired. Miss Gyer had been social service director since 1947 and a member of the hospital staff for 26 years. Miss Prichard was graduated from the New York School of Social Work of Columbia University. She has been chairman of the Committee on Information Services of the Welfare and Health Council of New York City for the last two years.

Simon Schapiro, controller of the North Shore Hospital, Manhasset, N.Y., has been appointed controller of the Hospital for Joint Diseases, New York City.

Vera Hosick, who was administrator of Hord Memorial Hospital, Central

City, Neb., has been named superintendent of nurses at Lutheran Hospital, Grand Island, Neb.

Frank P. Sanders, public relations director of Ohio Valley General Hospital, McKees Rocks, Pa., is now public relations and employe relations director at Atlantic City General Hospital, Atlantic City, N.J.

George L. Stevens has been appointed controller of Flower Hospital, Toledo, Ohio. For the last eight years Mr. Stevens has been assistant chief accountant in an industrial plant in Toledo.

Thomas A. Larkin, first assistant administrator at the Reading Hospital, Reading, Pa., has assumed responsibility for public relations and personnel. **Gerald P. Lorenz,** formerly office administrator, has been named second assistant administrator. He is succeeded by **Henry Conrad,** who had been assistant office manager.

T. K. Thompson

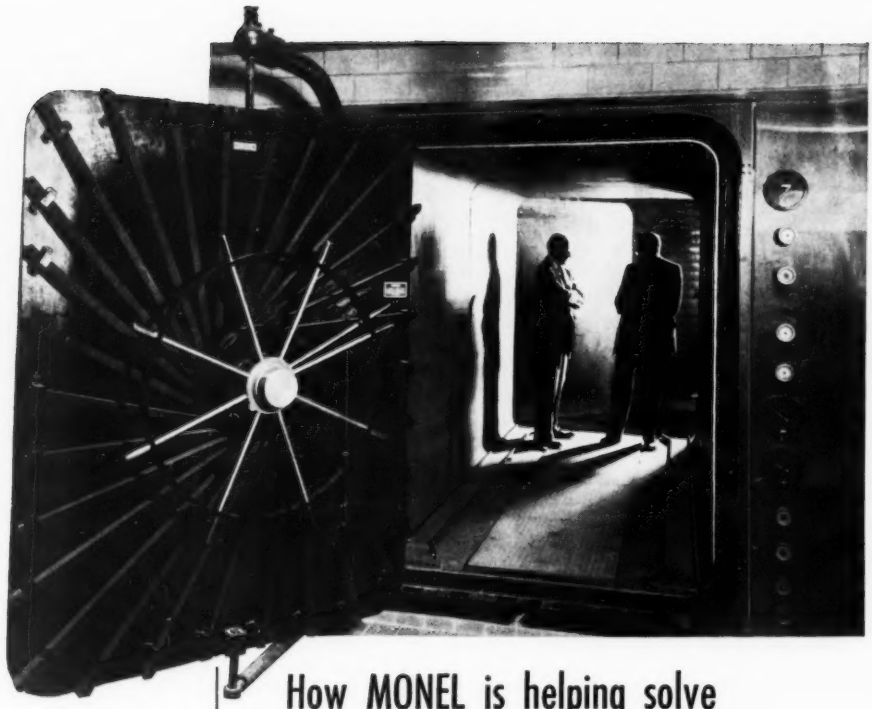
T. K. Thompson, media officer on the staff of the Commandant of the 12th Naval District, San Francisco, has been appointed public relations director of Hahnemann Medical College and Hospital, Philadelphia.

Pauline Saifer is the new personnel director at the Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N.Y. Miss Saifer has held supervisory personnel management positions with the Departments of the Army and Navy and Veterans Administration hospitals. For her services with the Department of the Army, Miss Saifer was honored with a Meritorious Service Award in 1946. She is a charter member of the New York chapter of the Society of Personnel Administration.

Miscellaneous

Cleveland Rodgers, who has been serving as executive secretary of the Mid-West Hospital Association and the Oklahoma State Hospital Association, as well as public relations director of the Oklahoma Blue Cross Plan, has resigned his Blue Cross position to devote full time to association work.

Dr. John C. Ullery, who has been assistant professor of obstetrics and gynecology at Jefferson Medical School, Philadelphia, a member of the faculty of the Graduate School of the University of Pennsylvania, and also chief of



13½ ton animal cage sterilizer.

This American Sterilizer unit is 10 feet, 10 inches long with a 62 by 80-inch Lukens Monel-clad inner chamber and two Monel-clad doors. It is a pressure unit, equipped for either steam or carboxide gas (for sterilizing heat sensitive plastics, instruments and clothing).

How MONEL is helping solve the sterilizing problem at the 500-bed National Institutes of Health Clinical Center

What The National Institutes of Health Clinical Center has done about its sterilizing problem is significant.

For this 500-bed, 14-story Public Health Service Hospital is *also* a gigantic medical research laboratory. It has all the sterilizing problems of an ordinary hospital . . . plus a host of others, such as the special requirements of animal experimentation.

At the Clinical Center pressure sterilization is done in Monel® and Nickel-clad units fabricated by American Sterilizer Company. Two 13½ ton, 15% Monel-clad sterilizers, like the one shown, handle animal cages and cage racks. Central Sterile Supply uses large rectangular Nickel-clad units; the Operating Suite, Monel pressure instrument washer-sterilizers.

Parts made of Monel include inner chambers, doors and rings, trays and racks. Other Monel components are used in the Pharmacy's water-distillation equipment. (In the building itself, Monel flashings prevent leaks in terraces and sun decks.)

The wide use of Monel in the Clinical Center's pressure sterilizing equipment is based upon its high resistance to corrosion . . . its easy cleaning properties . . . its high strength . . . its long life . . . its proved performance in thousands of pressure sterilizers.

You can be sure that in equipment of this type, Monel will give years of minimum maintenance service. So, if you are responsible for sterilization at your institution, be sure to consider Monel equipment.

And if you would like more information on solid Monel, Monel-clad, Nickel-clad all-welded sterilizers, write American Sterilizer Co., Dept. M, Erie, Pa., for their latest catalog.

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service, obstetrics and gynecology at Philadelphia General Hospital, Philadelphia Lying-In Hospital, and Delaware County Hospital, Drexel Hill, Pa., has been appointed professor and chairman of the department of obstetrics and gynecology at the College of Medicine of Ohio State University. Dr. Ullery succeeds **Dr. Allan C. Barnes,** who resigned in July 1953.

Dr. Charles F. Wilinsky, retired executive director of the Beth Israel Hospital and former deputy health commissioner of Boston, has been honored by the presentation of a fund to Harvard University for the establishment in its school of health of the Charles F. Wilinsky lecture fund. Given by Dr. Wilinsky's children and grandchildren, the fund will be used to bring to the school the nation's leading hospital administrators to discuss the rôle of the hospital in public health. Dr. Wilinsky, who retired from his post with Beth Israel Hospital in 1953, gave the first lecture in April in the series which will henceforth bear his name.

Ruth Allene Mercer, director of nursing at Perth Amboy General Hospital, Perth Amboy, N.J., has been appointed a member of the New Jersey State Board of Nursing for a five-year term, succeeding **Edna M. Antrobus,** whose term has expired.

Deaths

Leonard Schomberg

Leonard Schomberg, administrator of Little Traverse Hospital, Petoskey, Mich., died recently at the hospital. Before coming to Little Traverse in 1939, Mr. Schomberg had been associated with the old Petoskey Hospital and then had been administrator of the Burns Clinic in Petoskey. He had been a trustee of the Michigan Hospital Service for the last six years and was a former president of the Michigan Hospital Association.

Dr. M. Edward Marten, deputy chief medical examiner of New York since 1926, died recently. Dr. Marten, who was graduated from Bellevue Medical College, New York City, was a lecturer at the police academy and consulting pathologist at Wycoff Heights, St. Catherine's and Bethany Deaconess hospitals, all in Brooklyn, N.Y.

Sister Mary Veronica Ryan, former administrator and director of the hospital school of nursing at Mercy Hospital, Chicago, died at the age of 86. She was one of the organizers of the Catholic Hospital Association of the United States and Canada and was a fellow of the American College of Hospital Administrators.

Dr. James Winfield Doughty, who had been superintendent of Northern State Hospital, Sedro Woolley, Wash., from 1914 to 1950, died recently at the age of 88.

Sister Mary Eugenia Meyer, O.P., 88, administrator emeritus of Mary Immaculate Hospital, Jamaica, N.Y., and former administrator of St. Catherine's Hospital, Brooklyn, N.Y., died recently following a long illness. She had retired from active work in 1946.

Dr. Grace Atkins Holmes, 78, Elizabeth, N.J., founder of the Presbyterian Hospital in San Juan, P.R., which started as a free clinic in a shack and grew to be one of the largest medical centers in the Caribbean area, died recently. She had retired three years ago after many years of medical practice in this country. She went to Puerto Rico in 1901 as a medical missionary and pursued her work there until 1917.

READ WHAT A USER OF EMERSON-ELECTRIC ROOM AIR CONDITIONERS SAYS...

Cools quickly, uniformly, quietly

Here is a statement from a man who has installed Emerson-Electric Room Air Conditioners, and in a comparison test considers them his best buy:

"You will be interested in our experience with your new Emerson-Electric Room Air Conditioners, which we purchased several weeks ago.

"We equipped some of our units, last season, with another nationally known make of conditioner, which was reported to be the best on the market.

"Now, after four weeks of service, I can emphatically say that the Emerson-Electric DeLuxe Room Air Conditioner is far and away a much superior product. It cools quicker, more uniformly and is quieter in operation. That is just what we have come to expect from a product with the Emerson-Electric nameplate. We are well satisfied."

Keep this in mind when you are making your selection. Remember, too, that on a "years of service" basis the least expensive room air conditioner is the one that will operate year after year at maximum efficiency with a minimum of attention.

You'll find Emerson-Electric DeLuxe Room Air Conditioners, in ½-, ¾- and 1-ton sizes, your best buy. Get complete information by writing for Catalog No. RC 65.

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Emerson-Electric Fans mean cool summer comfort, too!

WINDOW FANS—Two-speed, reversible and non-reversible, in 16″, 20″, 24″ and 30″ blade sizes. Silver gray enamel finish. 5-Year Guarantee.

LOW-TABLE FAN—12″ blades, 3-speed motor, finished in metalescent mahogany. 5-Year Guarantee.

Exclusive! ***EVENAIRE*** **uniform wall-to-wall cooling**

EMERSON ELECTRIC
DeLuxe
ROOM AIR CONDITIONER

THE BOOKSHELF

CONDUCTIVE MATERIALS FOR OPERATING ROOMS. *Special report issued by the research department of the Hospital Bureau of Standards and Supplies. New York: Hospital Bureau of Standards and Supplies, Inc. Mimeographed. Pp.* 20.

The pace for this excellent research report is set in the foreword by Dewey H. Palmer, when he states: "The danger from explosions cannot be reduced by halfway measures. *All* objects must be conductive." Further along in the foreword he says: "It is possible that a major development in the elimination of static charges may result from the use of radio-active materials."

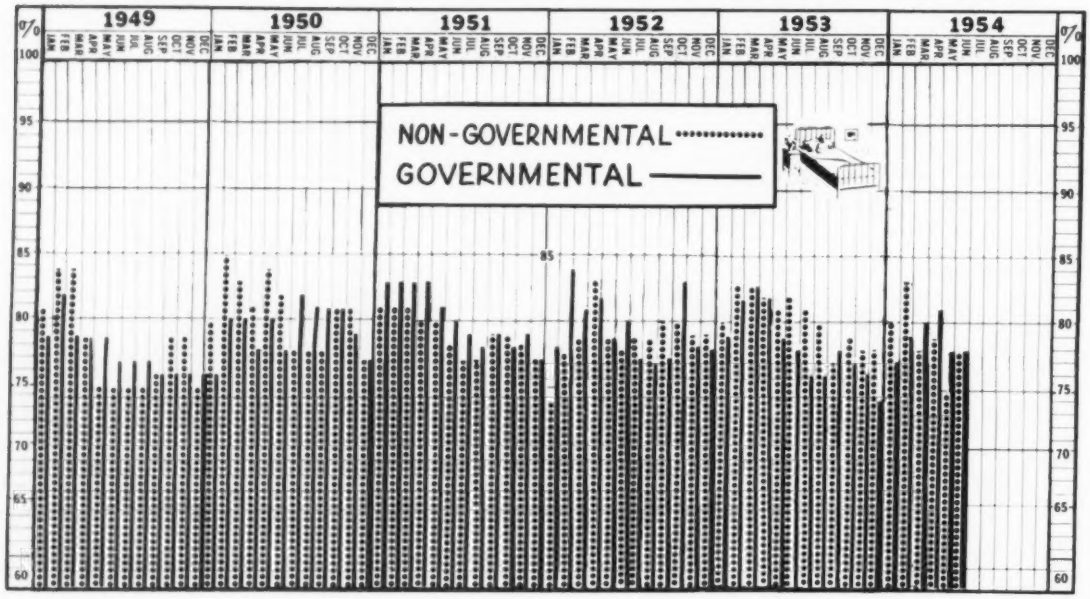
The report begins with a clear-cut statement of the nature of the problem facing hospital groups. "X-ray machines represent the most hazardous item used in operating rooms. The Underwriters' Laboratories has established certain requirements for x-ray machines and the major manufacturers are now developing explosionproof machines that can be used with safety in the operating room," the report asserts. *"Using halfway measures may be worse than doing nothing at all,"* the report makes plain. "Installing a conductive floor without creating a conductive link to it with all equipment and personnel will create an unjustified sense of security."

Because of the occasional administration of oxygen to patients, an interesting point brought up in the report is the use of plastic materials on patients' beds. Some hospital administrators, knowing that plastic materials are great storers and generators of static electricity, have been troubled about this. The report states, in this connection: "Oxygen in itself is not an explosive gas and the discharge of an electric spark in an oxygen atmosphere will not, therefore, cause an explosion. The use of synthetic fabrics or of plastic sheeting, such as vinyl, polyethylene and the like, is therefore not considered hazardous in patients' rooms." The report then quotes a supporting statement from George H. Buck, administrator of the University of Maryland Hospital in Baltimore and chairman of the committee on hospital operating rooms, National Fire Protection Association.

Conductive flooring is discussed thoroughly in the pamphlet, and a list of such floorings now approved by the Underwriters' Laboratories is given. Also listed are approved floor waxes and polishes for conductive operating room flooring.

Another section of the report discusses conductive furniture and casters, suction, pressure, anesthesia units, and rubber sheeting and pads. Other subjects treated are grounding of personnel, testing instruments to test the conductivity of operating room floors, static indicators, combustible gas detectors, shoe conductivity testers, and x-ray equipment. A valuable bibliography follows the report. This pamphlet is a distinct contribution to a vexing hospital problem. — EVERETT W. JONES.

Hospital Construction Figures Total $250,773,258



Government hospital reports to the Occupancy Chart for the month of June indicate an average daily occupancy of 77.7 per cent—slightly under last year's figure of 78.3 per cent. Voluntary hospitals averaged 77.9 per cent of capacity during June; a year ago 81.1 per cent of capacity was reported.

Through the current construction period of June 28 to July 12, hospital building totaled $24,448,716. For the corresponding period last year, $18,042,231 had been reported. Total construction for the year to date is $250,773,258. Of the 33 current projects, 22 were hospitals and nine were additions. One alteration project and one nurses' home were reported.

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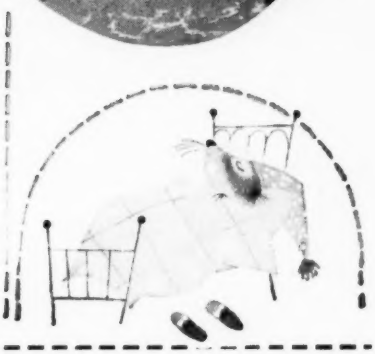
the quiet floor with the built-in bounce

When you want a *showpiece* floor . . . specify Gold Seal Rubber Tile. It's so resilient it puts wonderful comfort into footsteps . . . hushes every room to soothing quiet. This magnificent resiliency helps it do *the best job* of resisting indentation from heavy furniture and leather heels . . . keeps it from chipping or cracking! Gold Seal Rubber Tile has a beauty that lasts its life through . . . needs little upkeep. Its *clearer, truer, more beautiful colors* suggest an endless variation of appealing design combinations. Now in 21 marbleized colors. Standard and ⅛" gauges. 6" x 6", 9" x 9", 12" x 12" tiles.



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MH-8

Architects' Service Dept.
Congoleum-Nairn Inc., Kearny, N. J.

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POSITIONS WANTED

ANESTHETIST — Nurse; A.A.N.A. member; salary and maintenance. MW 35, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—M.D.; familiar all methods anesthesia; 7 years experience; seeks hospital appointment or group association; salary or percentage; now available. Reply MW 38, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; fifteen years' experience, five and a half years under medical anesthesiologist wishes to free lance; consider any location. Reply MW 53, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—Superintendent; 20 years experience in small hospital; administration 35-100 beds; prefer southeast or middlewest; available after August 1. Reply MW 56, The Modern Hospital, 919 North Michigan Avenue, Chicago 11.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR—Physician, well trained and well experienced; M.S. Hospital Administration; administrative internship and two years, assistant administrator, teaching hospital; five years, director, large teaching hospital.

ADMINISTRATOR—M.S. Hospital Administration; administrative residency, teaching hospital; three years, assistant director, 400-bed hospital.

ANESTHESIOLOGIST—Diplomate; eight years, private practice, on faculty, medical school.

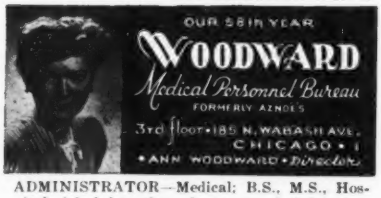
COMPTROLLER—B.A., Wisconsin; four years, accountant, three years, comptroller, 300-bed hospital.

PATHOLOGIST—Diplomate; three years, assistant professor of pathology, medical school and associate director, teaching hospital; since 1947, director, pathology, 350-bed hospital.

PURCHASING DIRECTOR—B.S. degree; eleven years, purchasing director, large teaching hospital.

RADIOLOGIST—Diplomate, six years, chief of department, teaching hospital and associate professor of radiology, university medical school.

PERSONNEL DIRECTOR: M.S. Hospital Administration; two years, personnel director, 200-bed hospital.



ADMINISTRATOR—Medical; B.S., M.S., Hospital Administration; 5 years, administrator, university hospital 500-beds; member, ACHA.

WOODWARD—*Continued*

ADMINISTRATOR—Lay; 35; B.S., Business Administration; M.S., Hospital Administration; 8 years, assistant manager, large commercial company; 2 years, administrator, 100-bed hospital; 6 months, administrative residency, 500-bed university hospital; 1 year, administrative residency voluntary general hospital 200-beds.

ADMINISTRATOR—Assistant; R.N.; woman; B.S. Nursing; M.S. Hospital Administration; 3 years private duty; 8 years head nurse; 3 years clinical instructor and assistant director nurse all at same 300-bed hospital; 5 years, assistant director nursing service; 600-bed hospital; finishing years' administrative residency; middle 40's; single.

ADMINISTRATOR—Lay; assistant; 29; B.A.; M.H.A.; completing year's administrative residency; 700-bed general voluntary hospital; seeks administrative assistantship; hospital 200 beds up or directorship, hospital 50-100 beds.

ANESTHESIOLOGIST—Trained university hospital; Diplomate; 7 years, chief, 700-bed hospital; middle 40's.

COMPTROLLER OR ACCOUNTANT—10 years accounting experience, including 2 years principal and instructor accounting business institute and 6 years public accounting.

PATHOLOGIST—32; M.D., George Washington Medical; board eligible; excellent residency including university hospital; currently, pathologist large teaching hospital.

PURCHASING AGENT — 31; B.A.; 2 years stock clerk 350-bed hospital; 5 years purchasing agent voluntary general hospital 350-beds; seeks purchasing agent larger hospital or assistant administrator with purchasing; prefer New England or east.

RADIOLOGIST—31; Diplomate, both branches; trained university hospital; past year private practice, radiology; prefers hospital position as chief.

RADIOLOGIST—31; diplomate; diagnostic and therapeutic; trained university hospital; past 18 months, chief, radiologist; 500-bed hospital and consultant several smaller hospitals; seeks chief, hospitals 300-600 beds.

SCIENCE INSTRUCTOR—39; B.S., single; 7 years science instructor large hospitals; prefers teaching; east.

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Miss Elsie Dey, Director

332 Bulkley Building

Cleveland, Ohio

EXECUTIVE HOUSEKEEPER—2 years college; housekeeping training under G.I. Bill of Rights; 300-bed southern hospital; 5 years executive housekeeper, 400-bed hospital.

NURSE SUPERINTENDENT — M.H.A. Degree, 1954; previous experience as assistant superintendent, 180-bed Ohio hospital; also trained anesthetist; available.

BUSINESS MANAGER—5 years office manager—accountant; 200-bed New Jersey hospital; 2 years assistant administrator, 250-bed New York hospital.

ASSISTANT ADMINISTRATOR—B.S. Degree, Michigan state college; industrial experience; 2 year course in hospital administration; 1 year residence, 200-bed Ohio hospital.

ADMINISTRATOR—F.A.C.H.A.; 15 years assistant director, 350-bed outstanding hospital, mid-west; past 5 years director, 200-bed hospital, Virginia; experience in directing building program; excellent references.

(Continued on page 190)

POSITIONS OPEN

ANESTHETISTS—Nurse; for 150-bed general hospital; four nurses, full-time M.D., all agents and techniques; one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

ANESTHETIST—M.D.; female, 29; trained at outstanding center; four years experience; available June 15. Reply, MW 34, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETISTS—Nurse—two; above average salary; medical anesthesiologist in charge. Apply, C. K. Shiro, Administrator, Montana Deaconess Hospital, Great Falls, Montana. Call at hospital expense.

ANESTHETIST—Nurse; 250-bed general hospital; salary $425.00-$500.00; vacation, sick leave, etc. Apply, The Ohio Valley Hospital, Steubenville, Ohio.

ANESTHETIST — 99-bed general hospital in northwestern Pennsylvania; salary open; partial maintenance. Apply, Administrator, Adrian Hospital, Punxsutawney, Pennsylvania.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. **Write: Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.**

ANESTHETIST—Nurse; for approved 160-bed pediatric hospital; 40-hour week, liberal vacation policy and other benefits, salary open; anesthesiologist in charge. Apply, Administrator, Milwaukee Children's Hospital, 721 N. 17 Street, Milwaukee 2, Wis.

ANESTHETIST—Nurse; for 210-bed hospital on beautiful shores of Lake Michigan between Milwaukee and Chicago; fine working conditions and good salary. Apply, Riley McDavid, Administrator, Kenosha Hospital, Kenosha, Wisconsin.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN — Assistant therapeutic; position open in 225-bed general hospital with school of nursing; qualifications: ADA or B.S. in Foods and Nutrition; central New York state Finger Lakes region. Contact: Personnel Director, Auburn Memorial Hospital, Auburn, New York.

DIETITIANS—Openings for 2 A.D.A. dietitians; 40-hour week; free Blue Cross, excellent salary and life insurance, 3 weeks paid vacation, etc. Trumbull Memorial Hospital, Warren, Ohio.

DIETITIAN—Chief; 350-bed tuberculosis hospital situated approximately 60 miles from Montreal in heart of Laurentian mountains; full maintenance is provided in residence; state qualifications, salary expected and when available. Apply, Mr. C. F. Ellis, Assistant Administrator, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec, Canada.

classified advertising

POSITIONS OPEN

DIRECTOR OF NURSING EDUCATION—B.S., capable of organizing and conducting a school of practical nursing; salary open; 40-hour week. Apply, Mrs. Marion G. Lamy, Superintendent, Moore General Hospital, Grasmere, New Hampshire.

INSTRUCTOR—Clinical, in obstetrics; 332-bed hospital located in an attractive residential section; student body of 160; Degree in Nursing Education and some teaching experience preferred; salary range for 40-hour week, $320-$430; beginning salary commensurate with experience and preparation; liberal personnel policies; living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTORS — Nursing arts and science; for fall term 1954; progressive 200-bed hospital; approved school of nursing; admit one class yearly; beginning tremendous expansion program in school; degree and experience desired; excellent salary commensurate with qualifications and experience; transportation paid for interview of desirable applicants. For information, write: Mrs. Rita H. Smith, Director of Nurses, The McLeod Infirmary, Florence, South Carolina.

INSTRUCTORS—Science and Nursing Arts; wanted for September; school with approximately 90-100 students: Apply, Director of Nurses, Victoria Public Hospital, Fredericton, New Brunswick, Canada.

INSTRUCTRESS — Female; qualified instructress for Homewood Sanitarium; capable of teaching psychiatric nursing to affiliating students; good salary; living accommodation available. Apply, Superintendent of Nurses, Homewood Sanitarium, Guelph, Ontario, Canada.

INSTRUCTOR — Clinical - Maternity; modern 400-bed hospital; student body of 100; good personnel policies; salary commensurate with positions. Apply, Director of Nursing, Kitchener Waterloo Hospital, Kitchener, Ontario, Canada.

MEDICAL DIRECTOR—Assistant; 100-bed tuberculosis hospital; North American graduate; salary $8500; complete maintenance. Apply, Medical Director and Superintendent, District One Tuberculosis Hospital, Madisonville, Kentucky.

MISCELLANEOUS—Operating room supervisor, Nurse anesthetist, and Laboratory x-ray technician wanted for 40-bed hospital in resort town north of Saginaw, Michigan; new facilities, excellent personnel policies; 40-hour week. Apply, Mrs. Wilma M. Cooper, Tolfree Memorial Hospital, West Branch, Michigan.

(Continued on page 192)

NURSE—Assistant superintendent; knowledge of operating room essential; small hospital in central New York; salary according to qualifications; position open August 1; inquiries confidential. Apply, Superintendent, Lenox Memorial Hospital, Canastota, New York.

NURSE—Head; delivery room; 332-bed general hospital with school of nursing; Degree and experience desired; 40-hour week, liberal personnel policies, living accommodations available, salary commensurate with qualifications; position available immediately. Apply, Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

NURSES—Graduate; positions open for two graduate nurses who either have, or are willing to obtain Colorado registry; floor duty, rotating shifts; starting salary $250.00 per month, 44-hour week; laundry furnished; under social security; two weeks paid vacation per year; high in the new Uranium country. Apply, MW 48, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

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with mops made of DU PONT SPONGE YARN

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These new mops do a better, neater all-around cleaning job . . . and they do it quicker! Made of the same tough work-saving material as famous Du Pont Cellulose Sponges, they last longer than ordinary mops . . . save you money.

Mops made of Du Pont Sponge yarn are *perfect* for waxing. The uniform strands apply wax evenly, then rinse out readily for use as a wet-mop, too.

No wonder more and more institutions are finding it *pays* to use these new and better mops. Give them a trial . . . find out for yourself how they save *you* time and money. Ask your supplier for mops made of Du Pont Sponge yarn.

- **Du Pont Sponge yarn outwears ordinary mop yarn 3 to 5 times.**
- **Works as both wet mop and waxer, wax rinses out easily!**
- **Highly absorbent, holds many times its weight of water.**
- **Easier to clean, always keeps a good appearance.**
- **Doesn't tangle, leaves no lint, no flags.**

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Cellulose Sponge Section A, Wilmington 98, Del.

Please send me my free copy of the new booklet describing Du Pont Cellulose Sponge yarn's advantages for floor cleaning and maintenance.

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NURSES—Operating room: experienced; five day, forty hour week; overtime compensated by pay or time off. Apply Monterey Hospital Ltd., Monterey, California. Phone Monterey 5-5161.

NURSES—Operating room and staff; 100-bed general hospital; salary $280 per month; 40-hour week; $10 differential afternoon, night, and surgery duty; annual vacation and raises; 7 paid holidays, sick leave and free hospitalization and insurance. Apply, Director of Nurses, Mercy Hospital, 4001 J. St., Sacramento, California.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Registered; 50-bed three year old hospital in Chicago suburb, near Fort Sheridan and Great Lakes Naval Station. Reply, Highwood Hospital, Highwood, Illinois.

NURSES—Psychiatric: The Institute of Living, one of the nation's outstanding psychiatric hospitals, has available staff appointments in psychintric nursing; 375-bed hospital for care and treatment of all types of psychiatric patients; an active program of rehabilitation as well as attractive nursing residences on the grounds of this well established institution; within walking distance of downtown Hartford and the cultural advantages of Connecticut's capital city; many learning opportunities. Write to Miss Regina Driscoll, Director of Nursing, 200 Retreat Avenue, Hartford 2, Connecticut.

NURSES—Registered; a few positions for general duty and operating room nurses immediately available at The Waltham Hospital, Waltham, Massachusetts; hospital fully accredited; is situated in pleasant suburban location, eight miles from Boston; base rate of pay 40 hours; time and one half for overtime; average work week, 44 hours; automatic pay adjustment semi-annually for first two years; increased pay for evening and night shifts; social security, retirement plan, sick leave, paid vacations, paid holidays; living-in facilities available; ample opportunity for advancement for qualified employees. Apply to Director of Nursing in writing, or call WAltham 5-1630.

NURSES—Staff; for hospital in college town; all registered staff; months paid vacation; two weeks sick leave; holidays; meals, laundry furnished. Apply, Superintendent, Allen Hospital, Oberlin, Ohio.

(Continued on page 194)

NURSES—Registered; general duty, all shifts, in a new and beautifully equipped 72-bed general hospital located near Kentucky Lake area, town of 12,000 population; beginning salary $270.00 for 44 hour week; 40 hour week optional, regular increases, two weeks vacation, holiday and sick leave benefits; differential for evening and night duty; overtime paid at private duty rates. Apply, Director of Nursing, Henry County General Hospital, Paris, Tennessee.

NURSES — Psychiatric: for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; for operating room and general floor duty. Apply, Martinsville General Hospital, Martinsville, Virginia.

NURSES — Graduate, female; general duty nurses for private psychiatric hospital; living-in accommodation if desired. Apply, Superintendent of Nurses, Homewood Sanitarium, Guelph, Ontario, Canada.

PHYSICAL THERAPIST — Registered; 160-bed general hospital in town of 24,000; modern facilities; salary commensurate with experience; good personnel policies: Write, Administrator, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

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Whether you describe your patients' charges by code key, a descriptive word, or by a column on the statement, the Burroughs Sensimatic Accounting Machine will do the job faster, accurately and more economically. You will like the ease with which daily charges can be entered under their proper heading to render a final statement. A duplicate copy—an automatic by-product—greatly simplifies the determination of amounts due from patients and from insurance companies.

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PHYSICAL THERAPIST—Registered; experienced in care of polio patients; salary open, depending upon experience and recommendation. Write, Sister Mary Aquin, Administrator, St. Rita's Hospital, Lima, Ohio.

SUPERVISOR — Teaching; operating rooms; 225-bed general hospital; nationally accredited school, 75 students; degree required or special preparation for the above specialty; 40-hour week; employee benefits. Apply, Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, California.

SUPERVISORS — Operating room supervisor and Assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

SUPERVISOR—Operating room; Northwest; 450-bed general hospital, new modern 11-room operating room suite; 40-hour week; $6000 for well qualified and experienced person; please state education and experience; liberal personnel policies. Apply MW 55, The Modern Hospital, 919 North Michigan Avenue, Chicago 11.

SUPERVISOR—Operating room; wanted within three months; experienced; 325-bed progressive, general non-profit hospital; located in Virginia; salary open. Reply, MW 54, The Modern Hospital, 919 North Michigan Avenue, Chicago 11.

TECHNICIAN—X-ray; registered; wanted for small active radiology department. Apply, Woodlawn Hospital, 6060 South Drexel Avenue, Chicago 37, Illinois.

TECHNICIAN — Laboratory; registered; 150-bed general hospital; three technicians under supervision pathologist. Write, Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS — (a) Director, medical center; currently 600-beds; expansion program; outstanding man required. (b) Large organization consisting of several treatment preventive medicine centers; slight preference for physician. (c) General hospital, medium bed

(Continued on page 196)

MEDICAL BUREAU—*Continued*

capacity, fully approved; California. (d) General hospital, 280-beds; expansion program will add 100 beds within year; $18,000; east. (e) Relatively new hospital, 140-beds; educational and research center; west. (f) Associate director, 400-bed general hospital; expansion program; duties include charge of all business aspects; university center, midwest. (g) Assistant administrator, university hospital operated under American auspices; major duties; training hospital administration students; foreign country. MH8-1

ADMINISTRATORS—WOMEN—(a) New hospital, 45-beds; resort town, two colleges; midwest. (b) Attractive home for older persons; 65 residents; Pacific coast. (c) Assistant; 400-bed general hospital; large city, medical center, midwest. MH8-2

ANESTHETISTS—(a) General hospital, 300-beds; university city, near several resort towns, south; $500 plus percentage, averaging $700-$800. (b) Association, 14-man group; college town near large city, medical center; $7200. (c) Small general hospital; near San Francisco. (d) Voluntary general hospital, 500-beds; interesting city outside US. MH8-3

COMPLETE STAFF—Heads of departments for voluntary general hospital currently under construction to be opened for operation summer of 1955; 300-bed increasing within few years to 700; attractive location offering opportunity for pleasant living. MH8-4

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIETITIANS—(a) Head; important teaching hospital; vicinity New York City. (b) Food service director by university; duties include teaching courses in Institutional Management; charge of college cafeteria, food service, two dormitories. (c) Assistant director, dietary department, large teaching hospital; university medical center; minimum $4800, perquisites. (d) Dietitian to take charge of department, 100-bed general hospital; college town located short distances two university cities; southwest. MH8-5

DIRECTORS OF NURSING — (a) Head, department of nursing, college for young women; young woman with limited experience but who shows promise eligible; east. (b) Dean, school operated by college, under its exclusive control; Pacific coast. (c) New hospital under American auspices; Near East; competent organizer required. (d) Assistant director qualified to succeed director within year or so; one of California's leading hospitals. (e) Large mental hospital; southwest. (f) Nursing service only; voluntary general hospital, 350-beds; attractive location, New England; $5000-$8000. MH8-6

EXECUTIVE HOUSEKEEPER—Teaching hospital, 350 beds; university town, minimum $5000. MH8-7

MEDICAL BUREAU—*Continued*

EXECUTIVE PERSONNEL—(a) Personnel directors; 700-bed teaching hospital; large city, medical center. (b) Chief comptroller; department staff of 25; 400-bed teaching hospital; university city, midwest. (c) Purchasing director; extensive experience on administrative level required; large teaching hospital; east. (d) Steward to serve as food supervisor; 300-bed general hospital; university city, south. (e) Business manager qualified to serve as assistant administrator; accounting background required; new hospital, 200-beds; midwest. MH8-8

FACULTY POSTS—(a) Chairman, university nursing education department; well qualified faculty; up to $9000. (b) Educational director and instructors in pediatrics, psychiatry, obstetrics; students mostly Orientals; large general hospital; 160 students; outside US. (c) Educational director; state college; university city, south. (d) Instructors in obstetrics, nursing arts; collegiate school; resort and college town, California. (e) Instructors in public health, medical and surgical nursing; department of nursing, large university; east. (f) Pediatric instructors for Brazil and India, psychiatric instructor for Brazil, nursing arts instructor for Jordan. (g) Instructors in anatomy and physiology for nursing students and physiology and hygiene for liberal arts students; east. MH8-9

(Continued on page 198)

MEDICAL BUREAU—*Continued*

MALE NURSES—(a) For medicine, surgery, night duty; 200-bed general hospital; medical center, midwest. (b) Anesthetist; small general hospital; $8-$9000. MH8-10

MEDICAL RECORD LIBRARIANS — (a) Chief; general hospital, 450-beds; large city, midwest; $5400 increasing to $6400. (b) Chief; small general hospital; resort town, Southern California. (c) Chief; 400-bed hospital; school to be established; New England. (d) Chief; medical school teaching hospital; staff of 10; university city, west. MH8-11

STAFF AND SURGICAL—(a) Staff; all departments; new hospital recently completed; unit, university group; opportunity continuing studies; west. (b) Surgical nurse; 10-man group; town 90,000, near large medical center, southwest. MH8-12

SUPERVISORS — (a) Operating room; new hospital, air-conditioned, excellently equipped; 10-12 cases daily; college town, South Carolina. (b) Central supply and communicable diseases; teaching hospital; university city, midwest; opportunity continuing studies. (c) Pediatric and obstetrics; 300-bed hospital; university town, south. (d) Thoracic surgery; new department, 400-bed hospital; near university center; interesting opportunity; east. (e) Obstetrical; new, large general hospital, modern every way; attractive city; although tropical country, climate mild, pleasant. MH8-13

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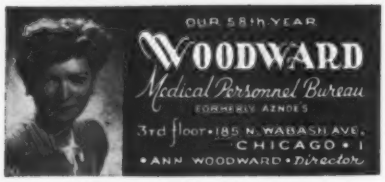
POSITIONS OPEN



ADMINISTRATORS — (a) Medical: to direct administrative program general hospital 600-beds; medical school affiliation; requires one qualified to develop strong residency program; will have lay administrator assistant; should be FACHA; $15-$20,000; West-coast. (c) Medical: State school; 5000 patients; very complete facilities. (d) Medical; one of country's most important hospitals; 2000 beds; medical school affiliation; metropolis; east. (e) Lay; administrative services director; general hospital 2500 beds; medical school affiliation; $10-$12,000; large city; east. (f) Lay; general hospital 200 beds; $15-$18,000; east. (g) Lay, assistant; voluntary general hospital 250 beds recently opened; about $7200; college town 100,000; southwest. (j) Supervisor of medical extension; important university; promote and develop refresher courses for M.D.'s, some travel;

WOODWARD—*Continued*

$5000 plus expenses; should have Business Administration degree; university town 100,000; southwest.

ADMINISTRATORS—Women—(b) Voluntary general hospital 50 beds; expansion program; near Washington, D. C. (c) General hospital 60 beds; short distance to Gulf of Mexico; southeast. (d) R.N.; lovely home for elderly people; in no sense an institution nor are residents inmates; about 50 women, 15 men; good salary; lovely apartment; large city Pacific northwest.

ADMINISTRATIVE EXECUTIVE PERSONNEL—(a) Chief admitting officer; voluntary general hospital 260 beds; university town 100,000; famous resort area; near Buffalo. (c) Business manager; 250-bed hospital; medical school affiliation; $6-$7000; south. (d) Business manager; group, 10 Diplomates; modern clinic; California. (e) Comptroller; 100-bed hospital; near Norfolk. (f) Personnel director; general hospital 800 beds; medical school affiliation; department staffed by 8 well qualified persons; 1800 employees; prefer man; consider woman; to $8000; large city; midwest. (i) Purchasing agent with hospital experience; voluntary general hospital 350 beds; university city 400,000; midwest.

ANESTHETISTS—(b) 130-bed general hospital; $7200; excellent winter, summer resort; Michigan. (c) General hospital 125 beds; about $6000; east. (d) Male R.N.A.; small general hospital; should net minimum of $8-$9000; mid-

(Continued on page 200)

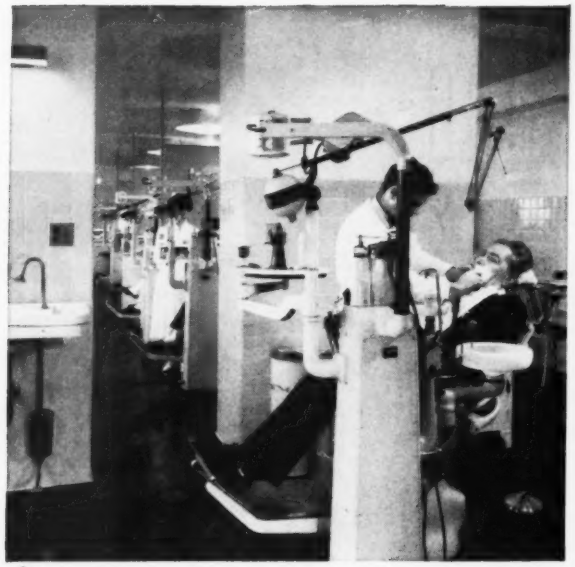
WOODWARD—*Continued*

west. (e) Clinic staffed by 15 distinguished specialists; 2 anesthetists on duty; minimum call; $7200; midwest.

DIETITIANS — (a) Food service manager; fully approved hospital 300-beds; to $6000; large city; south. (c) Chief; 200-bed general hospital; to $4800 and part maintenance; town 15,000; near university city; midwest.

DIRECTOR OF NURSES—(a) Director of nursing education and training; 4 year degree program; important medical school; requires M.S.; about $6000. (c) Head university department of nursing; rank of assistant professor; middle east.

FACULTY APPOINTMENTS — (a) Educational director—nursing arts instructor; administrative experience and B.S. required; 36 students in university affiliated school; new 150-bed hospital; excellent medical staff; substantial salary with or without maintenance; New York State. (b) Clinical instructor; 50 students at present; wish to expand to 75; 150-bed general hospital; to $4800; attractive city 25,000; midwest. (c) Nursing arts instructor; requires B.S. and 1 year teaching experience; school of nursing temporary NLNE accredited; 200-bed general hospital; minimum $4300; California. (d) Science instructor; class of 100 accredited each year in temporary accredited training school; fully approved 550-bed general hospital; to $5100; city of 100,000; east.



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POSITIONS OPEN

BUSINESS AND MEDICAL REGISTRY (Agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

DIRECTOR OF NURSES—Industrial company hospital, 25 beds, 16 patient average; supervision outpatient clinic also; should know surgical technique; staff includes 11 nurses, 7 doctors; cooperative group; $400 plus room and board, 40-hour week.

GENERAL DUTY—35-bed California hospital seeks 3 to 11 nurse; $15 per eight hours, may work 5 or 6 day week; room and meals furnished; $30 per month.

LABORATORY AND X-RAY TECHNICIANS—Two southern California clinics have openings; 5-day week, no call. $375-$400.

LABORATORY TECHNICIAN—Los Angeles internist offers $350 for five day week, Monday through Friday, no call.

DIETITIAN—College seeks dining hall manager to supervise food preparation, kitchen help and assist in menu planning for 500 resident students; $325-$415 plus two meals; 12 months' basis.

BUSINESS AND MEDICAL REGISTRY —*Continued*

DIETITIANS—Several needed as managers of school lunch cafeterias in southern California; $375-$400 monthly; 10 months' basis; weekends and holidays always free.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
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PERSONNEL DIRECTOR—Top level position with one of country's most important hospitals; approximately 1500 employees; require educational training plus good background as executive in hospital personnel work; this is an excellent opportunity.

BUSINESS MANAGERS—(a) East; 200-bed hospital; complete charge of business office; prefer good background in accounting. (b) West; 200-bed general hospital; good background in accounting and management; 12 employees in office. (c) Middle west. 200-bed general hospital; require someone who can set up procedures, establish standard policies and supervise the business office completely.

DIETITIANS—(a) Chief; east; 500-bed general hospital; 70 employees in department; supervise teaching program; $4000. (b) Assistant; 250-bed general hospital, fully approved; facilities complete and modern; $3600-$4400.

SHAY—*Continued*

(c) Therapeutic; middle west; 320-bed general hospital located within commuting distance of Chicago. (d) Therapeutic; middle west; 175-bed hospital fully approved; $4200 to $4800. (e) Chief; east; 350-bed general hospital, fully approved; located in city of about 50,000; $4800.

PHARMACISTS—(a) Middle west; 200-bed hospital, fully approved; 4 in department; $4800. (b) Northwest; set up and supervise pharmacy; 2 employees in department; 200-bed general hospital; $4800. (c) West; 600-bed general hospital; 5 pharmacists in department. (d) East; modern general hospital of 150 beds located in lovely resort area; duties will include supervision of central stores department and purchasing; $6500. (e) Middle west; 150-bed hospital located in thriving city of 50,000; set up and supervise new pharmacy; $5200.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 150-bed Michigan hospital. (b) 85-bed Ohio hospital. (c) 50-bed Nebraska.

NURSE ADMINISTRATORS—(a) 50-bed Ohio hospital. (b) 35-bed home for aged, newly organized; east. (c) 35-bed Idaho hospital. (d) New hospital; Iowa.

(Continued on page 202)

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

CONTROLLERS—(a) 450-bed Michigan hospital. (b) 300-bed Ohio hospital. (c) Assistant; 500-bed hospital, Pennsylvania. (d) Office manager; 55-bed Ohio hospital.

EXECUTIVE HOUSEKEEPERS—(a) 250-bed hospital, suburb New York. (c) 175-bed hospital, northern Ohio. (d) 200-bed hospital, Massachusetts. (e) 150-bed Illinois hospital. (f) Resident directors.

DIRECTORS, SCHOOLS OF NURSING—To $6,000 maintenance.

DIRECTORS, NURSING SERVICE—$400; maintenance.

RECORD LIBRARIANS—East, mid-west, south: to $400.

ANESTHETISTS—(a) Minnesota; $500, meals. (b) Pennsylvania; $500. (c) Southwest; open.

LABORATORY TECHNICIANS—(a) Ohio; $350. (b) X-ray, mid-west; $350. (c) Laboratory, x-ray; southwest; $400.

INDIANA MEDICAL BUREAU
212 Bankers Trust Building
Indianapolis, Indiana

ADMINISTRATORS—(a) 100-bed midwestern hospital. (b) R.N. and N.A. for small western hospital, salary $450 to $500. (c) Interesting position for capable woman; east.

INDIANA MEDICAL BUREAU
—Continued

ANESTHETISTS—(a) Chief, 350-bed midwestern hospital, $425-$500. (b) Staff, 250-bed midwestern hospital, $500. (c) 55-bed midwestern hospital. (d) 50-bed midwestern hospital.

ADMINISTRATIVE PERSONNEL—(a) Personnel director, 300-bed southeastern hospital. (b) Personnel director, 550-bed midwestern hospital. (c) Chief admitting officer, 300-bed southeastern hospital.

PHARMACISTS—(a) 400-bed midwestern hospital, staff; start $325; can consider incomplete internship. (b) 130-bed midwestern hospital, new graduate acceptable, base $375. (c) 550-bed midwestern hospital. (d) 250-bed midwestern hospital, $350.

PATHOLOGISTS—(a) 400-bed midwestern hospital, Board man or eligible, for one month summer or fall; acting pathologist. (b) Pathologist for several small West coast hospitals, equipment furnished.

PHYSICAL THERAPISTS—(a) 116-bed midwestern hospital; $350. (b) Small West coast hospital; $450. (c) 165-bed midwestern hospital.

MEDICAL RECORD LIBRARIANS—(a) 650-bed university hospital; midwest; $375-$420. (b) 70-bed eastern hospital. (c) 200-bed midwestern university hospital. (d) 225-bed midwestern hospital. (e) Assistant for 600-bed midwestern hospital; to $350.

(Continued on page 204)

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
311 Land Title Building
Philadelphia 10, Pennsylvania

RADIOLOGIST—Full time basis; 257-bed leading hospital; New England.

RESIDENT PHYSICIAN—200-bed convalescent hospital; older man preferred; $4200 plus family maintenance.

PHYSICAL THERAPIST—Large university student health department; required also to teach one course; $3600 plus maintenance; 40-hour week; liberal personnel policies.

REFERENCE LIBRARIAN—School of nursing large hospital; 40-hour week; salary open.

SOCIAL DIRECTOR—Nurses training school; 375-bed hospital; Physical Education major; 40-hour week.

DIRECTOR—School of practical nursing; 5 day 40-hour week; start $3600; vacation and holidays with pay.

DIRECTOR OF NURSING SERVICE—To act also as assistant superintendent; 75-bed hospital; New York City area.

ASSISTANT MEDICAL RECORD LIBRARIAN—500-bed general hospital; $4000.

MEDICAL RECORD LIBRARIAN—145-bed hospital; registration not required; $3000 plus maintenance.

RESIDENT NURSE—Co-educational college; start $2500 plus full maintenance; position open any time between now and September 15th.

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Foreward by E. Dwight Barnett, M.D.

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What's New for Hospitals

AUGUST 1954 Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 216. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Stainless Steel Dispenser for Milk Formula

A new device is available for dispensing milk formulas with minimum possibility of contamination. The entire unit is constructed of stainless steel, which can be completely and easily cleaned and sterilized, and a latex rubber tube through which the formula flows. The tube itself is also easily cleaned and sterilized and is disposable for periodic replacement.

The new milk formula dispenser consists of a 10½ quart stainless steel container for mixing formula and a 10½ quart dispensing container mounted on a stainless steel stand. The formula flows from a stainless steel spout through the latex rubber tube and is controlled by a simple clamp on the tube. The stand is fitted with rubber tips to avoid marring work surfaces. The parts are carefully constructed to eliminate recesses where contamination might develop. **S. Blickman, Inc., Weehawken, N.J.**

For more details circle #178 on mailing card.

Bedpan Washer-Steamer Re-Designed

New styling and improved design and operation make the Ohio Bedpan Washer-Steamer a more efficient unit. It is designed to decontaminate bedpans quickly and efficiently with a minimum of effort. A soft tubular gasket completely seals the door and prevents odors from entering the room. The stainless steel cradle firmly holds any standard size bedpan or urinal and is located at a convenient height. Forceful flat streams of water give a highly effective washing action and the full pressure steaming removes oil film and greasy residue. The heated bedpans dry quickly.

The toggle lock on the stainless steel door is easy to operate and may be opened with a slight touch of the foot, hand or forearm. The unit is constructed of stainless steel with green trim. The vitreous porcelain body is free of joints and crevices and the washer is designed to meet all requirements of approved safe plumbing practices and to eliminate the chance of water supply contamination. **Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.**

For more details circle #179 on mailing card.

Incubator Nebulizer Is Easily Attached

The new Armstrong X-4 Nebulizer, for use with the X-4 Baby Incubator, can be attached without drilling or cutting the incubator in any way. It takes only a few minutes to attach to the outside of the incubator, where it operates safely and produces a very fine mist. The Nebulizer can be as easily removed if not needed without damage or change to the incubator. Complete instructions for installation and operation are provided.

The Nebulizer is designed to produce supersaturated atmospheres with a high oxygen concentration, with a low oxygen concentration, without oxygen through the use of compressed air, and for the controlled administration of wetting agents, detergents or other medication. **The Gordon Armstrong Company, Inc., 1501 Euclid Ave., Cleveland 15, Ohio.**

For more details circle #180 on mailing card.

(Continued on page 210)

Liquid Deodorizer Is Long-Lasting

RX-54 is the name of a highly concentrated deodorant developed for hospital and medical use. It comes in a wick-type bottle for air deodorizing and has a dropper-type cap for use in bed pans, mop buckets, paint and for other direct applications. It removes odors without substituting another and is said to keep the air fresh for long periods. **Splain and Lloyd, Inc., Milford, Ohio.**

For more details circle #181 on mailing card.

Rocking Bed Has Three-Crank Spring

Polio and other patients who would benefit from the effect of a rocking bed can now be cared for in the one unit. The Emerson Rocking Bed is now available with a three-crank spring, thus eliminating the need for two beds and for moving the patient from one to the other.

The Emerson Rocking Bed is available in adult and child sizes. The standard hospital Model RB has a handwheel at the side of the bed which permits adjustment of the angle of tip while the bed continues in motion. The bed can be rocked to a maximum of 60 degrees (30 degrees each way). It is designed to aid the respiration of patients with impaired breathing capacity and bridges the difficult gap from dependence on mechanical help to independence. Circulation is actively helped by the rocking motion

and nursing care is easier. The bed has adjustable footboards and foam rubber mattress. **J. H. Emerson Company, 22 Cottage Park Ave., Cambridge 40, Mass.**

For more details circle #182 on mailing card.

What's New . . .

Nurses' Cap Is Cool and Comfortable

Made of light weight "sanforized" muslin, the new "J" Cap for Nurses is cool and easy to handle. One size is suitable for use with short or long hair since the heat resistant elastic band gives flexibility to the cap. It fits comfortably and stays in place without the use of pins or other fasteners. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #183 on mailing card.

Oxygen Regulator Has Accurate Flow Control

The new Safe-Set is an oxygen regulator employing a new principle of pressure reduction resulting in accurate flow control in a small, light unit. The complete regulator, flowmeter and pressure reducing valve weighs only 40 ounces. Cylinder pressure is automatically reduced from 2200 to 50 pounds by the pressure reducing valve. The pre-set valve eliminates adjustment of gas at high pressure in the patient area. Maintenance on the regulator can be easily handled by hospital personnel without special tools. **Melchior, Armstrong, Dessau Co., Inc., Ridgefield, N.J.**

For more details circle #184 on mailing card.

Outdoor Lighting Unit Withstands Weather

A new lighting unit for entrances, parking lots and other outdoor areas is now available. The No. 415 Unit is made of metal and glass, the metal parts being of die-cast aluminum with a lacquered finish. The hood is constructed to withstand all weather conditions, assuring trouble-free operation. The glass assembly is composed of hundreds of glass prisms built to optical standards to direct the light downward and outward for wide coverage. **Holophane Co., Inc., 342 Madison Ave., New York 17.**

For more details circle #185 on mailing card.

Dishwashing Compound Cuts Plastic Stain

Designed to prevent the formation and build-up of stain on plastic and china tableware, Kloro-K-O-L is a new mechanical dishwashing compound. Without change in methods or concentration, the new product provides superior cleaning as well as stain control. The result is obtained from a combination of effective wetting and stabilized bleaching action. It removes heavy stain build-up in a short time, at specified concentrations, and functions as both dishwashing compound and de-staining dip. It is packaged in 200 pound drums. **The DuBois Co., Inc., 1120 W. Front St., Cincinnati 3, Ohio.**

For more details circle #186 on mailing card.

Duplicating Process Does Not Stain

Lack of stain on hands, clothing and copy work with the patented Azograph duplicating process is an outstanding feature of this new development by A. B. Dick Company. Approximately fifty clearly legible copies can be produced with speed and economy from one master. No time is required for the operator to remove stains, which are non-existent with the new process.

The two color-forming compounds

within the coating of the transfer sheet are chemically separated so that no stain can be transmitted when handling the masters. The compounds are components used in the formation of azo dyes, thus giving the new process its name. The third element, to form the deep blue color and cause the duplicating process, is introduced within the duplicator.

Two machines are available for use with the new process. Both the manually operated 220 model and the new electrically operated 230 duplicator just introduced can be used either for Azograph or for aniline dye process duplicating. Since the Azograph fluid may be used in machines for either process, it need not be changed for running either type of master. The new Azograph process should have many uses for instructions, hospital forms and memorandums, systems work and any other work requiring quick, clean copies from a short run. **A. B. Dick Company, 5700 W. Touhy Ave., Chicago 31.**

For more details circle #187 on mailing card.

(Continued on page 212)

Carbon Paper Does Not Smudge

Fresh copy that cannot be smudged is produced with a new pen or pencil carbon paper introduced by the Burroughs Corporation. Called "Nu-Kote," the carbon is extremely long wearing and produces bright carbon copies. It is a non-tack, non-curl carbon produced without the use of a back coating. The carbon which is available in black, blue and red, produces a number of legible copies with little pressure. **Burroughs Corporation, Detroit 32, Mich.**

For more details circle #188 on mailing card.

Paper Electrophoresis System Offers Simplicity in Use

The new Spinco Model R Paper Electrophoresis System offers simplicity in use and reproducibility of results. Without special training, clinical and research laboratory personnel can routinely handle all steps in the separation of blood sera and other biological fluids, including the final automatic chart recording and numerical analysis of component concentration in the specimen. The power supply can be used with either constant-current or constant-voltage output and the indicating meter for voltage and current checking is easy to read. Two electrophoresis cells can be operated from a single power supply and the electrical connections are interlocked with a low-voltage relay controlled system which obviates accidental contact with the high voltage circuit. **Specialized Instruments Corporation, 666 O'Neill Ave., Belmont, Calif.**

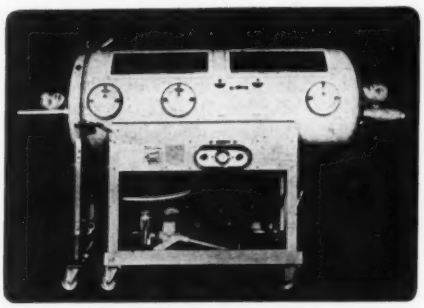
For more details circle #189 on mailing card.

Ice Packs Require No Ice

Patient comfort and convenience for the nurse are twin advantages of the Davol new Redi-Freeze Packs. The soft, flexible, pliable packs, pre-filled with a special non-toxic solution of isopropyl alcohol and water, are placed in a freezing unit and are ready for use at any time. The solution freezes to a slush or semi-solid providing needed cold. Packs

are available in three styles: for child's throat, for adult throat and for adult general body ice pack. **Davol Rubber Company, Providence 2, R.I.**

For more details circle #190 on mailing card.



LEARN WHY DRINKER-COLLINS DUPLEX GIVES DOUBLE VALUE

Not every hospital can afford two respirators—but if you specify a Drinker-Collins Duplex, you will have the equivalent of two respirators at the price of only one. One Drinker-Collins Duplex can treat TWO children in an emergency and save a second life while another machine can be obtained later.

NEW FREE BOOKLET

Printed in four colors it pictures the important features of the Drinker-Collins Duplex Respirator. Advantages of the sloping front, positive pressure breathing attachment and all other accessories for patient comfort and easier nursing care are pictured and described. The new juvenile model is also shown. You'll save this 12 page booklet, for it shows the very latest developments in Iron Lung construction and design.

ASK FOR BOOKLET M

WARREN E. COLLINS, INC.
Specialists in Respiration Apparatus
555 HUNTINGTON AVE., BOSTON 15, MASS.

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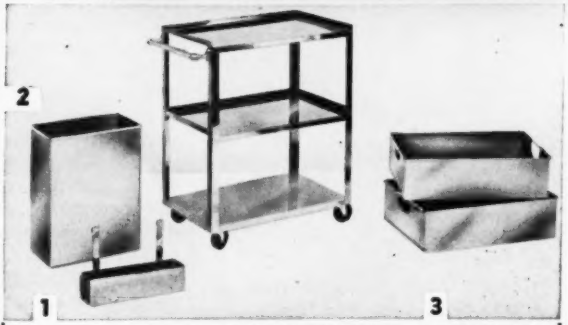
You will have to use "Dexter Diapers" to believe them. They go on and off baby in a jiffy—without folding, save half the changing time in your nursery. In your laundry they are easier to count, wash, dry, wrap, need no folding, take up less room, last longer, cut your laundry costs right in half. They are nationally advertised in 26 publications as an institution diaper. Ask your Diaper Service Company or write direct to Dexter Diaper Factory for sample and free booklet with facts about diapering written by a famous physician.

DEXTER DIAPER FACTORY, HOUSTON 8, TEXAS

"Our new Bloomfield truck paid for itself in 3 months!"



CUT OVERHEAD COSTS
with STAINLESS STEEL ALL-PURPOSE TRUCKS *by* BLOOMFIELD

Model No. 56 (above)

All-purpose trucks by Bloomfield are designed to serve efficiently and quietly in every part of today's modern hospital. Ideal as: *a kitchen truck, *surgical instrument cart, *medicine cart, *hospitality cart, *maid's truck *for transporting diathermy equipment, *for virtually every hospital moving job. *Write for information on specially designed trucks to meet other needs.*

MODEL NO. 56 LOW-COST TRUCKS

Model No. 56 (photo above) is a low-cost, sturdily made truck that will give years of useful service. Made of mirror-finished Enduro stainless steel, it can be kept perfectly clean with just minimum care. Available with or without stainless steel accessories as shown. Dimensions 27" long (including handle) x 31" high & 15½" deep. Price—$29.95.

MODEL NO. 36 HEAVY-DUTY TRUCK

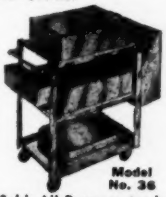
Model No. 36 is a ruggedly built truck, larger than No. 56 above, and is designed for durability and performance. Easily carries 350 lbs. Made of finest quality, heavy-gauge stainless steel, beautifully mirror-polished for complete cleanliness. Mounted on soft rubber-tired, ball bearing casters. Soundproof. Available with or without accessories. Dimensions: 30" long (including handle) x 31" high x 16½" deep. Price, $36.95.

ACCESSORIES FOR NO. 36 TRUCK

1. No. 236 Bin—Same as above.
2. No. 136 Bin—Same as above.
3. No. 37—Carrier—Smoothly finished stainless steel, with extra reinforcement, and rolled handles. Larger than No. 57 above. Price—$12.50.

LOW-COST ACCESSORIES FOR NO. 56 TRUCKS

1. No. 236 Bin—For silverware, condiments, medicines, other small items. Easily removable. Price—$6.49.
2. No. 136 Bin—For food scraps soiled or clean linens. Quickly cleaned. Removable. Price—$12.95.
3. No. 57 Carriers—For carrying foods, candles, bottles, dirty dishes, etc. Leakproof, sanitary. Smooth rolled handles. Price—$10.50.



Model No. 36

Bloomfield All-Purpose trucks can also be supplied in extra heavy gauge galvanized steel for use where stainless steel is unnecessary.
Model No. 34 (same dimensions as No. 36). Price—$22.95.
Galvanized steel accessories similarly low priced.

SEE YOUR JOBBER

Please send me complete details on Bloomfield All-Purpose trucks. Also send my copy of the new Bloomfield catalog of more than 200 important hospital items.

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What's New . . .

Wall Outlet Assemblies for Central Oxygen Supply

Compact, flush-mounted wall outlet assemblies are now available in single or multiple units for oxygen, nitrous oxide, vacuum and compressed air. The Puritan wall plate assemblies have non-interchangeable quick-connect valves which connect only to the proper equipment for each specific type of service. They are designed for either concealed or exposed central supply systems, in single or multiple units, for individual gases or any required combinations.

An exceptionally strong assembly box anchors firmly to the wall containing the valve itself and a heavily chromed brass wall plate. Apparatus is easily and efficiently connected or disconnected without the sound of escaping gas. A built-in service valve inside the assembly box simplifies maintenance. **Puritan Compressed Gas Corp., 2012 Grand Ave., Kansas City 8, Mo.**

For more details circle #191 on mailing card.

Mattress Ticking Is Water Repellent

A new mattress ticking is being introduced which is treated with a new water repellent and spot resistant finish. Known as Permel Plus, the finish will be applied to a blue and white pin striped ticking for use on Airfoam mattresses. The finish resists spots from beverages such as coffee and tea, as well as stains from perspiration. Any spot on the Permel Plus treated ticking can be removed with soap and a damp cloth.

The new finish makes fabrics soil resistant. Zippered tickings so treated may be laundered. The treated ticking is made by the Swift Manufacturing Company, Columbus, Ga., and distributed through the contract division of **The Englander Company, Inc., Merchandise Mart, Chicago 54.**

For more details circle #192 on mailing card.

Redesigned And-O-Meter Measures Oxygen

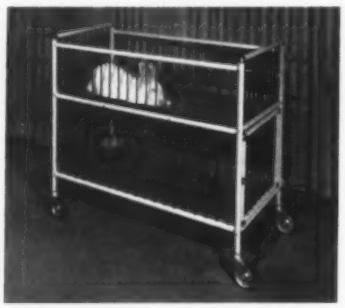
The volume of oxygen actually consumed by a patient, and the exact amount dispensed is told at a glance with the redesigned And-O-Meter. The simplified, improved dial is a time-saver and prevents errors in calculation of liters used. The versatile device can be used with most types of oxygen therapy and the slip-on hose connection and universal bracket fit all standard sized tubing.

The compact, convenient device, light in weight, scientifically registers up to 24,000 liters of oxygen consumption, either continuous or intermittent. It simplifies medical records and billing procedures in oxygen therapy, providing metered cost control. The newly improved dial eliminates the task of marking report charts. The easily-read numerals, showing the exact amounts of oxygen used, appear in dial windows. **W. E. Anderson Inc., 2921 Brooklyn Ave., Kansas City 9, Mo.**

For more details circle #193 on mailing card.

Rolling Rabbit-Cart for Children's Wards

A new device to provide diversion and entertainment in children's wards is offered in the new Rolling Rabbit-Cart. It is actually a colorful cage and top deck for holding a live rabbit that can be wheeled easily into children's rooms and wards. Developed by Colin Campbell



McLean, the cart is a practical unit, well constructed and easily handled. It permits bringing the rabbit to the children, and where no infection is present, they can see, feed and care for the animal, providing a diverting interest. **Hospital Furniture, Inc., 936 N. Michigan Ave., Chicago 11.**

For more details circle #194 on mailing card.

Window Cleaning Tool Incorporates New Principle

A unique positive patented locking principle is incorporated into the new Tog-L-Lok Squeegee for speedy window cleaning. Composed of three parts: the channel, rubber and handle, the squeegee has a specially designed pattern which cuts a keen edge on steel, wood or putty and even permits cleaning of leaded glass. The brass channel is made of two pieces which lock together easily and simply after the rubber has been inserted. The finest quality rubber is used. **Tog-L-Lok Company, 314 Postal Bldg., Portland, Ore.**

For more details circle #195 on mailing card.

Defibrillator-Pacemaker in Combined Unit

The Morris Clinical Defibrillator-Pacemaker combines in a single unit facilities for both the direct application of electric shock to the heart ventricles in cases of fibrillation, and the external or internal application of controlled pulses to the heart for use in cardiac standstill and conduction block. Special safety features are incorporated into the unit which is operated by a minimum number of simple controls.

The Defibrillator unit provides three automatically-controlled pulse lengths but has manual facilities where the pulse length is directly under control of the surgeon. The instrument is instantly operative when turned on. In one model of the unit five steps of pulse amplitude are delivered. Another model provides continuously-variable amplitude. Shock rate is controlled by the surgeon from the panel switch or from an accessory foot switch. Closely regulated but adjustable serial pulses are produced by the Pacemaker unit, which can be used simultaneously with an electrocardiograph without interference. **Levinthal Electronic Products, Inc., 2868 Fair Oaks Ave., Redwood City, Calif.**

For more details circle #196 on mailing card.

Glare-Free Light With Nightingale Lamps

Diffused, glare-free light is provided by circular louvers shielding the bulb of the No. 404 Nightingale Floor Lamp. The distinctive styling makes it attractive and efficient. A lens on top of the reflector provides a concentrated spot of light of high intensity. The reflector rotates without injury to wires so the lens can be used in any position.

A night light is incorporated into the floor lamp. It swivels 180 degrees and can be used for many tasks without disturbing the patient. Two plug-in receptacles are located in the night light unit for convenience and efficiency. The weighted base keeps the lamp firmly in position, yet it can be easily moved when desired.

The lamp is 60 inches high and is available in baked enamel finishes in several colors. **Adjustable Fixture Co., 104 E. Mason St., Milwaukee 2, Wis.**

For more details circle #197 on mailing card.

What's New . . .

Mattress Covers in Tomac Nylonite

Nylonite Mattress Covers are light in weight yet strong. The material is nylon-cloth-inserted and coated with a special rubber resin compound. It is unaffected by oil, urine or phenol, does not harden, stiffen, tear or "draw," and will not support a flame. Corners are contoured for special fit and the triple-stitched seams are made to prevent pulling out. Pillow cases in Tomac Nylonite are also available with zipper closures. **American Hospital Supply Corporation, Evanston, Ill.**

For more details circle #198 on mailing card.

Rinse Dry System Eliminates Water Spotting

Water spotting on silverware, glasses and china can be eliminated, without wiping, with the new Rinse Dry System. The system embodies a new product and new equipment. The product, Rinse Dry, is a new nonsudsing drying concentrate. When pumped into the final rinse system of a dishwashing machine by means of the specially designed Rinse Injector equipment, the surface tension of the rinse water is lowered. Rinse water flows off completely, leaving no film or spots on the self-drying utensils. Tableware air-dries and is ready for service in a minimum of time. The Rinse Dry System produces equally good results on plastics. **Economics Laboratory, Inc., Guardian Bldg., St. Paul 1, Minn.**

For more details circle #199 on mailing card.

Automatic Ice Maker Produces Cubes and Chips

The new Model B-200 automatic ice maker is a compact, dual purpose machine that produces Crystal Tips, a solid ice cube, or chips at the turn of a selector switch, without a crusher mechanism. The chips or crushed ice sizes are suitable for ice bags, chilled beverages and

other uses in the hospital. The attractive, compact unit requires only six square feet of floor space and is low enough for under-counter installation, thus saving on floor space. Installation is simple and economical.

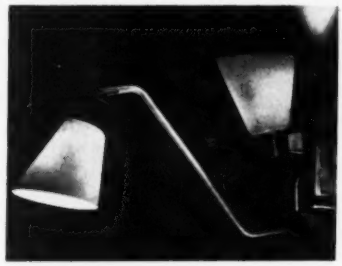
The machine manufactures up to 200 pounds of ice in a 24 hour period. Its size and ease of installation make it practical for use in floor kitchens or utility rooms. Ready-availability of the ice, both in cube and in crushed form, provides a labor-saving feature which can be considerable in a large hospital. **American Automatic Ice Machine Co., 4th St. & Park Ave., Faribault, Minn.**

For more details circle #200 on mailing card.

Hospitality Light for "Plug-In" Installation

A new feature of the Hospitality Light is the "plug-in" installation. All necessary electrical work can be done during construction or remodeling, and the fixture is easily installed to the electrical outlet by plugging it in and tightening two screws. In case of emergency repair the unit can be as easily unplugged and a spare unit plugged-in without patient discomfort or loss of time.

The unit combines indirect general illumination, reading light, examination light, night light and direct over-bed



lighting, as well as a convenient electrical outlet, in one compact, attractive fixture. The new spring balanced Uni-Versen swivel, specifically designed for the hard usage given institutional fixtures, has built-in positive stops to prevent the reading arm unit from interfering with the indirect unit or coming in contact with the wall. A complete line of twelve variations of models is available in the Hospitality Light. **Kurt Versen Company, Englewood, N.J.**

For more details circle #201 on mailing card.

Tenderizing Machine Has Stainless Steel Housing

Model 702-SS U. S. Tendersteak Machine is a new stainless steel machine with stainless steel housing. It has redesigned cutting blades, improved knitting action and faster tenderizing action. It is designed to comply with the most rigid sanitation requirements and has no painted or enameled sufaces. The durable, heavy-gauge stainless steel housing is easy to keep clean and sanitary. **U. S. Slicing Machine Company, Inc., LaPorte, Ind.**

For more details circle #202 on mailing card.

Anatomical and Equipment Data Provided in Fracture Chart

A helpful piece of equipment for the fracture room, orthopedic department and nursing school is offered in the new Zimmer Fracture Chart. The chart has 11 sheets, each containing information on a special type of fracture equipment and surgical appliances. The first page contains an anatomical chart of the front and rear of the skeleton with explanatory data corresponding to the numbered parts. The chart provides a valuable reference guide of equipment and appliances. **Zimmer Mfg. Co., Warsaw, Ind.**

For more details circle #203 on mailing card.

Curity Ward Pad Is Economical

A new Curity Ward Pad has been developed as a soft, strong, highly absorbent underpad for general hospital use. It can be sterilized and offers opportunities for savings in laundry cost. The soft, smooth cover sheet is gentle to the patient's skin, yet strong enough to protect the absorbent Cellucotton filler. It functions as a "transfer" dressing, delivering drainage promptly through to the filler. The pad is filled with six and one-half plies of Cellucotton. The filler extends to the edges of the pad and is anchored to the bottom sheet to prevent bunching or tearing. The bottom sheet is water resistant and overlaps the top sheet to prevent side leakage. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #204 on mailing card.

Redesigned Labels for Fruit Crystal Jars

Cramores Crystals are now offered with colorful, informative labels. These flavorful crystals, in lemon and other fruit flavors, are put up in the same convenient jar for shelf storage and preservation but the new label carries clear, complete instructions for the easy preparation of fruit flavorings, giving exact quantities and time-saving suggestions for their use. **Cramore Fruit Products, Inc., Point Pleasant, N.J.**

For more details circle #205 on mailing card.

What's New . . .

One-Hand Operation for Blood Pressure Reading

The new Propper Manuell Aneroid Sphygmomanometer is the result of a new idea in design. It is convenient to use, accurately read and requires only one hand for operation. The large, easy-to-read dial is attached to the pressure pump. The physician has a clear view of the monometer dial and can read the pressure in the palm of his hand without the patient seeing the dial.

The new instrument is available with the new snap-on cuff or the conventional wrap-around style. A zippered leather case, which can be carried in bag or pocket, holds the complete apparatus. **Propper Manufacturing Co., Inc., 10-34 44th Drive, Long Island City 1, N.Y.**

For more details circle #206 on mailing card.

Easy Chair Serves Dual Purpose

The Hard Dual Purpose Easy Chair No. 7242-W has an adjustable back. When locked in the upright position it serves as an attractive and comfortable chair for patient or visitor. With the chair back adjusted for reclining and the ottoman in position, it can be used as a change from the bed for the patient, or as a comfortable sleeping unit for relative or attendant.

The new chair is of Life-Long design with reversible inner-spring seat and back cushion and removable seat cushion retainer. Arms are available in metal, wood or matching upholstery and the chair is offered in a wide range of colorful plastic upholstery. **Hard Manufacturing Co., 117 Tonawanda St., Buffalo 7, N.Y.**

For more details circle #207 on mailing card.

Garfield Luminaire for Low Ceilings

The long, low lines of the Garfield luminaire make it particularly well adapted for use where low ceilings necessitate a shallow illuminating source. The new series is available in 2-lamp, 4 and 8 foot fluorescent luminaires. The unit has an overall depth of only 3⅞ inches with a width of 12½ inches for the 2-lamp luminaire. The Garfield may be ceiling mounted or suspended from hangers. Both sizes may be individually mounted or mounted end-to-end to form a continuous row.

The Garfield is built around a rigidly constructed chassis. Side panels of diffusing polystyrene and a bottom louver with 35 by 35 degree shielding give comfortable brightness. The permanently attached top-closure type reflector assures high efficiency and ease of maintenance. The units are wired completely, ready to install. **Pittsburgh Reflector Co., 482 Oliver Bldg., Pittsburgh 22, Pa.**

For more details circle #208 on mailing card.

Aluminum Safety Tread for Stairs

An easy, economical method of repairing worn stairway treads is offered in the new Wooster aluminum safety stair tread. Called the "Stairmaster," the tread has a permanent extruded light weight aluminum alloy base in standard 9 inch depth. It is furnished in lengths required and can be easily installed over worn stair treads after existing tread is leveled with mastic. The tread has eleven rows of firmly embedded safety ribs containing diamond hard abrasive grains for anti-slip protection. The Stairmaster has a 1⅛ inch lip which covers and protects the face of the stair tread. The light

weight, rustproof tread can be used for interior or exterior stairs. **Wooster Products Inc., Wooster, Ohio.**

For more details circle #209 on mailing card.

Conduit Union Is Explosion-Proof

Safety and ease of installation are features of the new, self-adjusting expansion type Explosion-Proof Conduit Union developed by Appleton. The self-contained unit consists of only two parts. It is permanently assembled at the factory and requires only two tightening operations. It is precison-built and explosion-proof under all conditions of expansion. A built-in phosphor-bronze spring ensures positive grounding at all times. Reduced external diameters permit easy installation in any location. **Appleton Electric Company, 1701 Wellington Ave., Chicago 13.**

For more details circle #210 on mailing card.

Card Transfer Speeded With Airtube Carrier

A new Airtube carrier has been developed which provides new convenience and efficiency in handling tabulating-machine or punch cards. There are no flaps and no ends to turn. Cards to be dispatched are slipped into a 7½ inch slot. An internal spring clip holds up to fifty cards firmly in place but permits them to be easily pulled out. The carriers are made of sheet aluminum for four inch tube systems. The new system is applicable for use wherever tabulating or punch cards are used in large quantities. **Lamson Corp., Syracuse, N.Y.**

For more details circle #211 on mailing card.

Kitchen Needs Combined in Single Unit

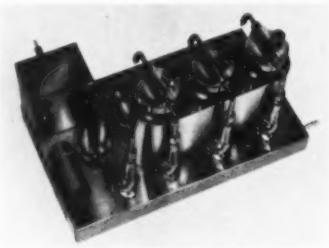
A new all-in-one kitchen unit, called the TWIN R-600, is now available for use in nurses' homes and personnel quarters. The new unit consists of a gas or electric range with three standard sized burners and an oven and broiler compartment; an electric refrigerator with a horizontal freezer that has a capacity for 9 ice cube trays or 12 frozen food cartons, and twin sinks and range top of white porcelain on heavy gauge steel. There is a deck type swing spout faucet and all corners are rounded for easy cleaning. This all-in-one unit takes up a minimum amount of space. **General Air Conditioning Corporation, 4542 E. Dunham St., Los Angeles 23, Calif.**

For more details circle #212 on mailing card.

Compact Unit Speeds Needle Cleaning

The Buechel Hypodermic Needle Cleaner, Model 200, is designed for fast, efficient cleaning. Needles are placed in detergent for a short time, rinsed in hot water, and then quickly cleaned. The hub of the needle is placed on the motor brush for cleaning, then the needle is placed on succeeding outlets for cleaning with detergent solution, distilled water and alcohol, then dried inside and outside. The machine is easy to operate and time, effort and solutions are saved in its use.

The Model 200 has stainless steel base and waste containers, polished aluminum jar caps, chrome plated brass tubing and valves and is powered by a continuous duty motor. The quick change brush



holder has a nylon brush and there is a small hand needle sharpener for use when needed. **Buechel Products Co., Foulke Station, Box 61, Richmond, Ind.**

For more details circle #213 on mailing card.

What's New . . .

Obstetrical Dressing Is Prepackaged

Prepackaged hospital dressings have proved to be time and labor savers in the hospital. They eliminate the need for special wrapping materials and the time required for wrapping. Prepackaged obstetrical dressings are now available in the Kenwood Dressing line. Long length, fluff cellulose Kenwood O. B. Pads are individually machine wrapped and sealed in a white paper wrapper. The sanitary package is easy to handle and ready to go directly from the shipping carton into the autoclave.

The paper used for wrapping has been tested and meets all requirements for porosity to steam, strength, color and storage properties. The pad is so folded and inserted into the wrapper that when it is removed the side worn toward the body does not need to be touched. **Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis.**

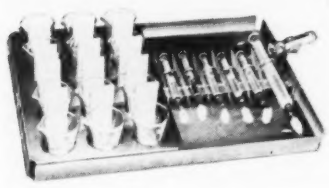
For more details circle #214 on mailing card.

Janitors' Wagon Has Spring-Steel Frame

Several new features are introduced in the new Janitor Service Wagon. It is equipped with white canvas or olive drab bag that is replaceable and washable. Metal grommets and drawstring permit quick and easy closure of the full bag when removing it from the frame. The spring-steel frame collapses into small space when the wagon is not in use. It is equipped with 2 inch hard composition casters but may be had with two 4 inch neoprene rubber wheels in back and two 2 inch wheels in front for easy rolling on carpeted or uneven floors. The wagon measures 20 by 19 inches and is 43 inches high with the bag open. **Meese, Inc., Madison, Ind.**

For more details circle #215 on mailing card.

Dispensing Unit Combines Five Needs



The Med-A-Tray is of all stainless steel construction. It offers a basic tray for any requirements, which will hold syringe cradles for 24 sterile syringes ready for use, two medicine cup trays holding a total of 24 medicine cups, or 12 medicine cups and 6 syringes. For surgery the syringe cradles can be used separately to prevent syringes rolling or rattling. **Midwest Surgical Manufacturing Co., 6333 Sprague, Omaha, Neb.**

For more details circle #216 on mailing card.

Instrument Lubrication in New Type Dispenser

A special dispenser is provided for Surgel Liquid (Ulmer) for lubrication in endoscopic procedures. A compressible polyethylene container with a special tip dispenses just the required amount of Surgel. The method is economical as there is no waste and no mess in the application. Surgel is water soluble, easily wiped off and leaves no stain. **The Ulmer Pharmacal Company, 1400 Harmon Place, Minneapolis 3, Minn.**

For more details circle #217 on mailing card.

High-Speed Centrifuge for Capillary Blood Tubes

The International Hemacrit Centrifuge was developed for use in the improved Guest-Siler time and labor saving method for rapid, accurate blood cell volume testing. The technic takes four simple and rapid steps: blood sample taken directly from finger in a heparinized capillary tube which can be used once and discarded; tube is sealed; sample is centrifuged four or five minutes at 11,000 r.p.m., and percent blood cell volume is read directly by means of a reader or microscope.

Designed specifically to spin 24 of the glass capillary blood tubes at speeds in excess of 11,000 r.p.m., the new International Hemacrit Centrifuge further simplifies the procedure. The high-speed rotating head is completely enclosed for safety and the tube slots in the head are individually numbered for easy identification of blood samples. The centrifuge operates automatically after turning the knob which starts the machine, sets the running time and shuts off automatically when completed. **International Equipment Company, 1284 Soldiers Field Road, Boston 35, Mass.**

For more details circle #218 on mailing card.

Pharmaceuticals

Ilidar

Ilidar is a potent adrenolytic agent which dilates peripheral blood vessels. It is indicated whenever there is vasospasm, in peripheral vascular disorders, in cold, aching extremities, in thrombophlebitis and the post-phlebitic syndrome, in certain types of muscular spasm associated with vascular spasm, in ulcers due to peripheral vascular disease, and in diabetic arteriosclerosis. Dilation of the peripheral blood vessels is caused by sympatholytic action, adrenolytic action, epinephrine reversal and direct vasodilation. Ilidar is supplied in coated tablets in bottles of 100 and 500. **Hoffman-La Roche Inc., Roche Park, Nutley 10, N.J.**

For more details circle #219 on mailing card.

Ophthalmic Ointment Ilotycin

A new addition to the Ilotycin family is offered in Ophthalmic Ointment Ilotycin, Crystalline, 5 mg. per Gm. It has been clinically demonstrated to be effective against virtually all gram-positive organisms and many of the gram-negative organisms which might cause infection in the eye. The ointment is supplied in $\frac{1}{8}$ ounce tubes. **Eli Lilly and Company, Indianapolis 6, Ind.**

For more details circle #220 on mailing card.

Steri-Vial Ambodryl Hydrochloride

Steri-Vial Ambodryl Hydrochloride provides the antihistamine, Ambodryl Hydrochloride, in a new form for the treatment of a wide variety of allergies. It is an aqueous solution for parenteral use in acute allergic states calling for immediate relief. It may be injected intravenously or intramuscularly. Dosage is determined by the type of allergic state being treated and its severity. The antihistamine is also available in capsule and elixir forms. **Parke, Davis & Co., Detroit 32, Mich.**

For more details circle #221 on mailing card.

Thorazine

Thorazine is a new therapeutic agent which has been under wide clinical study in Europe as well as in America. It depresses the functions of certain neural centers and is thus effective in the control of nausea and vomiting due to various causes, with effective control of severe and refractory cases of vomiting. It is described as effective whether given orally or intramuscularly. The drug is said to relieve certain neurotic conditions and psychiatric states and to induce an unusual type of sedation. Thorazine is supplied in tablet form in 10 mg. and 25 mg. strengths in bottles of 50, and in ampul solution for injection. **Smith, Kline & French Laboratories, 1530 Spring Garden St., Philadelphia 1, Pa.**

For more details circle #222 on mailing card.

What's New . . .

Product Literature

• Westinghouse Electric Corp., Sturtevant Div., Dept. T-126, 200 Readville St., Hyde Park, Boston 36, Mass., is offering two new catalogs. One is on **commercial and industrial heating and ventilating units,** and the other on **air conditioning units.** Each catalog is divided into five separate data sections: descriptive, performance, layout, engineering and service. Several hypothetical problems are calculated to show the proper use of performance data, curves and charts in selecting the correct unit.

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• **Bulletin No. 153-1, "Instant" Water Coolers,** available through Frick Co., Waynesboro, Pa., has just been released. The Bulletin shows some of the most important uses of these coolers and gives the principle on which the Instant Cooler operates.

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• How perforated acoustical baffles were used as warm air diffusion outlets in a translucent suspended ceiling is discussed in an **engineering report on tests** completed at Case Institute of Technology. The report, available from the F. W. Wakefield Brass Co., Vermilion, Ohio, shows a table of air flows versus pressures at inlet and gives complete information on the results of the tests.

For more details circle #226 on mailing card.

• Complete detailed information on the Selectotherm, brought out by Illinois Engineering Co., Div of American Air Filter Co., Inc., 2035 S. Racine Ave., Chicago 8, Ill., is given in Bulletin 540, **"Tune in With the Weather."** The material tells what the Selectotherm is, where it may be used, gives information on how the system functions and the engineering details, and lists some institutions where it has been used.

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• A new **brochure** describing **electrophoresis apparatus** is now available from The Perkin-Elmer Corp., Norwalk, Conn. A section on the use of electrophoresis in modern analytical technics is included in the brochure with specifications and descriptions of the components of the Model 38-A Tiselius Electrophoresis Apparatus.

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• Carolina Absorbent Cotton Co., Charlotte 1, N.C., has just released its new 56 page **Hospital Supply Catalog.** The catalog is divided into four divisions: Surgical Dressings, Textiles, Garments and Infants' Supplies. Full descriptive information and illustrations are given in each section and a price list is included with the catalog.

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USE THIS CARD

(We pay the postage)

This card is detachable and is provided for the convenience of our subscribers, and those to whom they pass their copies, in obtaining information on products and services advertised in this issue or described in the "What's New" Section. See reverse side.

August, 1954

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

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INSTITUTION _____

ADDRESS _____ CITY _____ ZONE _____ STATE _____

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181 RX-54 Deodorizer
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182 Rocking Bed
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Key

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199 Rinse Dry System
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Colorful TEA SERVICE


MANHATTAN


DETROIT


SAF-SPOUT


FRENCH


BUFFET


PITTSBURGH


PHILADELPHIA

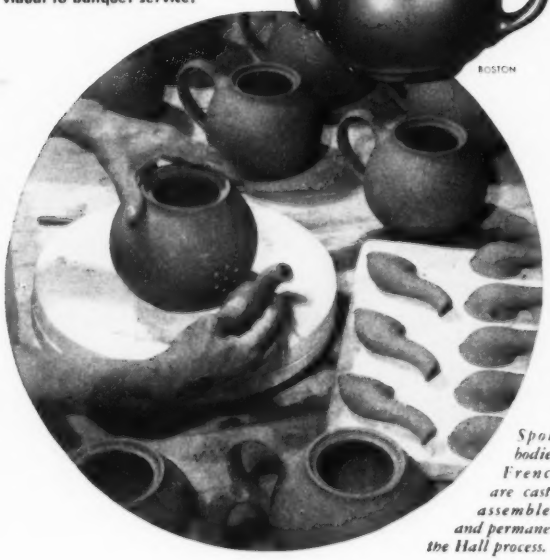

CHICAGO


BELLEVUE


NEW YORK


BOSTON

Hall Teapots are available in sizes ranging from individual to banquet service.



Spouts and bodies of Hall French Teapot are cast separately, assembled by hand, and permanently joined by the Hall process.

Use the appeal of a beautiful color in your tea service. Clear, brilliant Hall underglaze colors, fused with body and glaze by our single-fire process, will not fade or wear away. Your choice of color is available in all Hall China . . . casseroles, baking dishes, coffee and teapots, creamers, jugs, ash trays, and many other items. Write for color chart.

27 POPULAR HALL UNDERGLAZE COLORS

Black	Canary	Emerald	Green Lustre	Marine	Rose	Turquoise
Blue	Clay	Flesh	Ivory	Maroon	Sandust	Violet
Brown	Delphinium	Gray	Lettuce	Orchid	Sea Spray	Yellow
Cadet	Dresden	Green	Lune Blue	Pink	Tan	

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

HALL
Secret Process
FIREPROOF CHINA

Index to Products Advertised—*Continued*

Colorful TEA SERVICE


MANHATTAN


DETROIT


SAF-SPOUT


FRENCH


PITTSBURGH


BUFFET


PHILADELPHIA

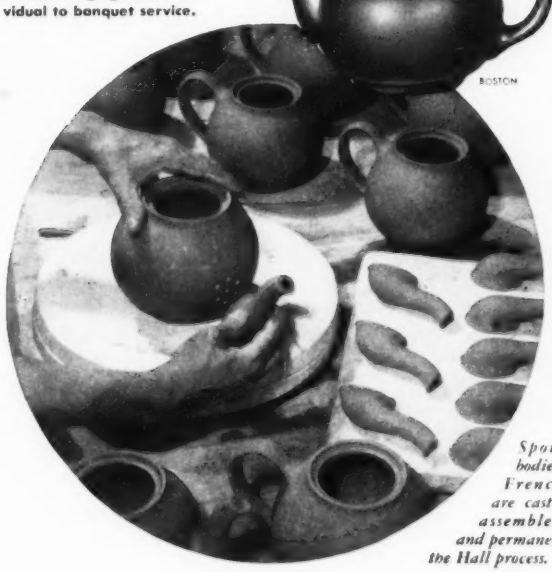

CHICAGO


BELLEVUE


NEW YORK

Hall Teapots are available in sizes ranging from individual to banquet service.


BOSTON



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THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

HALL
Secret Process
FIREPROOF CHINA

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED

CLAUDE E. HOOTEN
architect
DE LAUREAL & MOSES
engineers
HAASE CONSTRUCTION CO., INC.
general contractor
JAMES F. O'NEILL CO.
plumbing contractor
CRANE CO.
plumbing wholesaler

Fresh air is supplied to individual air conditioning units through intake louvers on the exterior face of the new TEXACO *building, between the vertical fins which decrease the sun heat load. (See circle above.)*

17 STORIES - NO BASEMENT!

• If you were in New Orleans and stopped to admire the 17 stories of architectural beauty bearing the well-known name TEXACO you would have no reason to suspect that under this modern building there is *no basement.* Because the site was soggy soil it was necessary to drive clusters of concrete piling to a depth of 85 feet and set the welded steel building frame on top of the groups of piling. To reduce the building load the frame was enclosed within curtain walls of aluminum and glass, and the broad vertical section which carries the TEXACO sign was faced with porcelain enamel panels. On exposures subject to direct sunlight aluminum fins decrease the heat load and reduce air conditioning costs. Individual air conditioning units, automatically controlled, are located beneath window sills. Two 200-ton refrigerating machines and two gas-fired steam boilers deliver cooling and heating to these units. As in a high majority of notable buildings of all kinds throughout the nation, SLOAN *Flush* VALVES, famous for efficiency, durability and economy were installed throughout the new TEXACO building—more evidence of preference that explains why . . .

more **SLOAN** *Flush* **VALVES**
are bought than all other makes combined

SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive folder